A Discursive Evaluation of Therapeutic Interactions Between Therapists and Service User During Cognitive Behavioural Therapy Sessions For Depression

Rowe, Lottie

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Abstract:

The aim of the thesis is to discursively examine therapeutic interactions between service users and therapists during Cognitive Behavioural Therapy (CBT) sessions for depression. It is argued that the discursive psychological approach is the most appropriate to explore this aim. The thesis provides a unique perspective regarding the construction of depression because it is the first discursive research to look at how service users and therapists jointly construct depression, how identities are constructed, how CBT principles are constructed in interaction and how cognitive behavioural strategies are implemented and attended to during therapeutic interactions. In total four research questions are addressed in this thesis: (1) How is therapeutic dialogue in CBT constructed and what does it accomplish? (2) How is depression constructed in CBT sessions? (3) What do the constructions of depression accomplish within therapeutic interactions? and (4) How is identity constructed and attended to during therapeutic interactions for depression? Recordings of sixteen, one-hour CBT sessions were transcribed and analysed using discourse analysis. The analysis of how depression is jointly constructed by service users and therapists in CBT sessions demonstrates that during therapeutic interactions depression is oriented to and talked about but the terms "depressed" and "depression" are often absent from the dialogue. In the unusual cases where the terms are present, it is used by speakers to demonstrate a lack of control, manage accountability and emphasise distress and the seriousness of depression. The analysis shows that the terms "depressed" and "depression" are used differently and were found to have different implications regarding aetiology, prognosis, trajectory and identity. This thesis identified five key discursive strategies that are used to construct the self and identities in CBT sessions for depression. The thesis assessed how CBT strategies work in interaction, and identified the extent to which they 'work' by identifying the discursive features of effective and ineffective implementation of CBT strategies. It is shown that while the therapist does accomplish the therapeutic aim, this can be done without displays of understanding and empathy which is incongruent with the ethos of CBT. These findings highlighted inconsistencies in CBT and that therapists are potentially being assessed on how well they can do contradictory things. In addition to adding to the current literature, the thesis identified two new conceptual issues which contribute to wider discussions. The first is that the terms "depressed" and "depression" are largely absent in CBT for depression and the second is the varied meanings of depression. The thesis could aid clinical practice because it provides an insight into how therapeutic dialogue is constructed and what it accomplishes.

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Thesis Overview:

The aim of the thesis is to discursively examine therapeutic interactions between service users and therapists during Cognitive Behavioural Therapy (CBT) sessions for depression. A chapter-by-chapter overview is provided below and a glossary of acronyms used throughout this thesis is provided in the appendix.

Chapter One:

Chapter one addresses what counts as depression. It first chronologically reviews how depression has been constructed and understood in psychology and psychiatry throughout history. It highlights the changes the term depression has undergone overtime and the varied constructions of depression. It then goes on to review how formal classification systems' conceptualisations of depression have changed over time. It also demonstrates that the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems (ICD), currently differ in their classification of depression. The lack of concordance suggests that a single universal conceptualisation of depression does not currently exist. The chapter concludes by examining how the cognitive model conceptualises depression, the aims of CBT, how a typical CBT session is structured and criticisms of CBT. Overall chapter one demonstrates that the conceptualisation of depression is a discursive process and that research needs to be conducted around how depression is constructed in talk.

Chapter Two:

Given the variability of how psychology and psychiatry have conceptualised depression, chapter two reviewed qualitative literature regarding how lay individuals conceptualise depression. The qualitative research highlights how individuals construct depression by focusing on word usage. This research provides an insight into how depression is constructed. However, the use of narrative analysis and corpus linguistic techniques means that the analysis does not provide any details regarding what these constructions of depression are used to accomplish, or how they are attended to by others. The research has simply highlighted that these ways of talking about depression exist. This demonstrates the need for a thorough analysis of the construction of depression.

Chapter Three:

Chapters one and two demonstrate that what counts as depression is determined by discourse and that different ways of talking about depression exist. This emphasises the importance of taking a discursive psychological (DP) approach to examine how depression is constructed during therapeutic interactions. A DP perspective was adopted because it addresses the way that activity constitutes or is constructed through discourse (Edwards and Potter, 2001). This is particularly pertinent with regards to therapeutic settings where therapy is constructed and achieved through discourse. DP offers a fertile scheme for interpreting and making sense of psychological talk (Edwards and Potter, 1992). Chapter three discusses social constructionism (the epistemological perspective underpinning DP), the key features of DP and how it can be utilised effectively in the current research project. It also critiques the literature presented in chapters one and two from a discursive perspective.

Chapter Four:

Chapter four aims to examine discursive literature regarding the construction of depression. It highlights the key discursive strategies lay individuals and professionals draw on to construct depression, and how depression has been constructed in public texts. This section aims to highlight how previous discursive literature has examined depression and highlights the gaps in discourse analytic research regarding depression. For example, to date mental health professionals' and service users' constructions of depression have been examined separately and via interviews. They have focused on explanatory frameworks, treatment choices and diagnosis. No research has looked at how depression is jointly constructed and attended to during therapeutic interaction. Furthermore, previous discursive studies highlight how individuals who previously had an episode of depression construct identity but do not examine how identity is constructed by individuals currently seeking help for depression during therapeutic interactions.

Chapter Five:

Chapter five aims to demonstrate how a discursive approach can be effectively utilised to analyse the sensitive and complex discourses occurring during therapeutic interactions. Chapter five reviews the limited number of studies that employed a

discursive methodology to analyse transcripts of psychotherapy sessions and gives a brief overview of conversation analytic studies of therapy sessions. It is demonstrated how a limited amount of studies have employed a discursive methodology to examine CBT and even fewer have analysed CBT therapy transcripts. To date no discursive research has looked at how CBT strategies are implemented and attended to or how items assessed via the CTS-r are constructed in talk. This highlights the need for a discursive analysis of therapeutic interactions between service users and therapists during CBT sessions for depression.

Chapter Six:

Chapters one to five established that discursive psychology is the most appropriate approach to explore therapeutic interactions between service users and therapists during CBT sessions for depression. The method associated with discursive psychology is discourse analysis (DA). Therefore, a discourse analysis was conducted on recordings of sixteen, one-hour CBT sessions. In the methodological approach section of chapter six, the key concepts of DA, and why it was chosen as the methodological approach in the current research project are discussed. The data and sample used within the current research project are explicated. Chapter six also details why using naturalistic data, such as recordings of CBT sessions, are beneficial and superior to other data sources. In addition to this chapter six provides details regarding how the analysis was conducted. The chapter concludes with the discussion of participant orientations and generalisability of the findings.

The next part of the thesis presents the findings of the research in the form of the analysis. The topics that are addressed in this analysis were chosen to deal with the overall aim of the thesis: to discursively examine therapeutic interactions between therapists and service users during CBT sessions for depression. In addition, the analysis focuses particular attention to the construction of depression and identity. It also offers an examination of the implementation of cognitive behavioural strategies and how they are attended to during therapeutic interactions. The analysis reflects the prominence of rhetorical strategies within these areas of focus.

Chapter Seven:

The first section of analysis focuses on therapeutic interactions more generally. Chapter ten explores how therapists implement CBT strategies, how they accomplished the therapeutic aim and how service users attended to therapeutic questioning. The analysis demonstrated the discursive features of effective and ineffective implementation of CBT strategies, examined where the strategies worked but neglected other aspects of importance highlighted by the service users and troubled responses. In doing this, the analysis provides an understanding of therapeutic processes. This understanding could aid clinical practice and highlight effective ways of communicating in therapeutic interaction to enable cohesion and therapeutic alliance.

Chapter Eight:

Chapter eight discursively examines how depression is constructed in CBT sessions, without utilising the terms "depressed" or "depression". It provides an understanding of the different constructions of depression and their discursive accomplishments. It also examines how the service user and therapist attend to these constructions within therapeutic interactions. In doing this, the analysis provides a unique perspective regarding the construction of depression, because to date no discursive research has looked at how service users and therapists jointly construct depression during therapeutic interactions. It is the first analysis to look at how depression is constructed in UK therapeutic settings. It also explores how the absence of the terms "depressed" and "depression" have clinical implications and orient to a need for delicacy. It highlights issues within clinical practice and how the absence of the terms indicates that depression may be stigmatised.

Chapter Nine:

Chapter nine examines the deviant cases in which the terms "depressed" and "depression" are utilised during therapeutic interactions. It explores how these terms are utilised, what they accomplish and how they are attended to within therapeutic interactions. It provides an understanding of how the terms are utilised to construct identity, manage accountability and legitimise behaviour and distress. In doing this, the analysis provides a unique perspective regarding the construction of depression. It explores what the various constructions mean and how the terms "depressed" and

"depression" are used to accomplish different discursive actions which have implications for aetiology, prognosis and trajectory. It emphasises that the terms are constructed hesitantly and the use of these terms need to be considered carefully in clinical practice.

Chapter Ten:

Chapter ten explores identity construction during therapeutic interactions for depression. It provides an understanding of how service users construct the self during CBT sessions for depression. It highlights what the different constructions of self accomplish and how they are managed and attended to within therapeutic interactions. In doing this the analysis provides a unique perspective regarding the construction of identity and explores how an understanding of identity construction in CBT could aid clinical practice. This is because previous literature regarding depression and identity construction were conducted retrospectively via interview and focused on individuals who had previously had an episode of depression. None of the studies examined how individuals currently seeking help for depression constructed identity during therapeutic interactions.

Chapter Eleven:

Chapter eleven brings together the thesis and highlights what the thesis has contributed to literature and clinical practice. The discussion chapter demonstrates how the aims of the thesis have been accomplished and highlights what we know now that we did not know before. Chapter eleven highlights how the thesis has: added to and developed previous literature, expanded knowledge regarding depression and therapeutic interactions, contributed to clinical practice and made recommendations for future research and CBT training, therefore demonstrating how the thesis has made a novel contribution to knowledge and could be utilised as a teaching resource for CBT training.

Chapter One - What Counts as Depression? Psychiatric and Psychological Conceptualisation of Depression in the Western World

1.1 Overview:

How depression is understood and talked about has varied throughout history. For example, the term melancholia, meaning 'black bile' first appeared in the Corpus Hippocraticum between 460- 370BC (Ban, 2014). In 1621Burton defined melancholy as a compensatory quality of brilliance, genius and creative energy, whereas Freud conceptualised depression as a way of expressing anger towards the world. The term "depression" was first introduced to the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1980 (American Psychiatric Association, 1980). The varied construction of depression can have important implications for clinicians and individuals with depression because the way we understand the world, and the categories and concepts we use are historically and culturally specific. Therefore, how depression is understood is dependent on the historical specificity of knowledge. This has implications for lay-individual's understanding of depression and influences how individuals discursively construct depression.

More recently, formal classification systems have been developed to categorise depression and its symptomology. However, the main classification systems, the DSM and The International Statistical Classification of Diseases and Related Health Problems (ICD), differ in their classification of depression. The DSM and the ICD currently have eight symptoms in common (see *section 1.2.3*.) but differ on the remaining items; ICD-10 has two additional symptoms, regarding self-esteem and guilt whereas the DSM has one additional symptom, worthlessness (First, 2007). This suggests that a single diagnostic classification of depression does not currently exist and the categories 'depressed or non-depressed' do not necessarily refer to real divisions. The lack of agreement between DSM and ICD has implications for academia and clinical practice because small differences in the discourse can lead to significant rates of diagnostic discordance (Saito *et al* 2013). Therefore to date there is not one universal definition of depression. This emphasises that there is disagreement over what counts as depression, thus more research needs to look at how depression is constructed.

The next section will review how depression has been constructed and understood, and the changes that the term depression has undergone over time. It will discuss the formal classification systems used to diagnose depression, how these classification systems

have changed and highlight the differences between the leading classification systems. The chapter will conclude by examining how the cognitive model conceptualises depression. This will provide an understanding of depression and the ways in which it has been constructed overtime to demonstrate that what counts as depression, is determined by discourse.

1.2 The Historical Conceptualisation of Melancholia and Depression:

The term melancholia (formed from two Greek words: *melas* (black) and *Khole* (bile) first appeared in the Corpus Hippocraticum between 460- 370BC (Ban, 2014). For over 1000 years, through the Middle Ages and the Renaissance, Greek science dominated the understanding of melancholia (Menninger, Mayman and Pruyser, 1968; Ban, 2014; Jackson, 1978). Greek science described health as a balanced relationship between the four humours present in the body: blood, yellow bile, black bile, and phlegm. An imbalance in the humours was thought to cause disease. Melancholia was considered to be a disease caused by excess black bile (Adams, 1929). Melancholia has been a term used to describe mental disturbances of a depressive nature since the Hippocratic times (Adams, 1929; Jackson, 1986; Varga, 2013). Gallen (129-199) revised the humoral theory of melancholia by marrying it with Aristotelian logic (Healy, 1997). Gallen claimed that "symptoms follow the disease as a shadow of its substance" (Ban, 2014: 7). He divided melancholia into general melancholia, brain melancholia and hypochondriacal melancholia (Garrison, 1929). These divisions occurred because Gallan postulated that the aetiology of melancholia was not restricted to black bile but included yellow bile, dietary deficiency, suppression of menstrual flow and emotional factors (Ban, 2014).

Interest in melancholia peaked in the 17th and 18th centuries (Starobinski, 1962; Wang, 2013). This early modern period witnessed a shift in the perception of melancholia from the Galenic humoral model to the new science where the humours were replaced by nerves, spirits, and fibres (Lawlor, 2013). In the 17th century there was a shift in emphasis from symptoms to disease. This commenced a new era in the understanding and classification of insanity (Faber, 1923). Sydenham (1624-1663) and his followers were the first to classify diseases and insanities (Ban, 2014). In Sauvage's (1768) nosology melancholia was classified as a disturbance of intellectual life and divided into 14 'species' of disease (Sauvages, 1768).

Shortly after Sauvage's (1768) nosology, Cullen proposed an alternative nosology of melancholia in 1769. Cullen (1769) perceived melancholia as a partial madness/insanity and distinct from mania, which was understood as a universal or total madness/insanity. This distinction between total insanity (mania) and partial insanity (melancholia) was retained throughout the 18th and 19th century. Cullen also divided melancholia into eight species of disease based on patient discourse i.e. "one's affairs are in a desperate state, or aversion from motion and from all offices of life". Chiarugi (1793) simplified Cullen's nosology into 'true melancholia', characterised by constant sadness of spirit and 'false melancholia' characterised by hatred and violence against oneself or others. Cullen's nosology was elaborated further in 1818 by Heinroth in *psychic life and its disturbances*. Heinroth (1818) conceptualised mental illness as depression of one or more faculty of the mind i.e. intellect, emotion or volition. He perceived melancholia as a partial insanity and a depression of emotion without the depression of other faculties.

As depression started to become associated with certain symptom clusters, a diagnostic classification of depression was required. Kraepelin (1883) founded modern scientific psychiatry and pioneered diagnostic classification (Lake, 2007; Wang, 2013). Kraepelin described and categorised the symptoms of patients, hypothesising that certain symptom combinations and trajectory allow for the identification of a particular mental disorder (Lawlor, 2013; Radden, 2000). Kraepelin published eight editions of his textbook. However, it was not until the fourth edition, published in 1891, that the unitary concept of melancholia, an illness characterised by retardation of movements and thoughts, was proposed (Kraepelin, 1891). The unitary concept of depression was originally restricted to endogenous depression, e.g. depression occurring due to internal attributions (Moebius, 1893). It was broadened to include "psychogenic depression" precipitated by life events (Wimmer, 1916) and "symptomatic depression" relating to somatic illness (Bonhoeffer, 1910). Kraepelin's system stood out as the most influential of its time (Lake, 2007; Wang, 2013). It dominated the classification and understanding of depression from 1883 until 1913 (Ban, 2014). Kraepelin's ideas and popularity were eclipsed by the rise of the psychoanalytic movement (Ghaemi, 2009).

Meyer (1866-1950) dismissed Kraepelin's unitary concept of depression and argued in 1905 for the term melancholia to be replaced by depression (Meyer, 1915; Healy, 1997; Ban, 2014). Meyer regarded depression as a reaction to a situation gone wrong and postulated a spectrum of reaction types to explain mental illness (Lawlor, 2013; Meyer,

1952). Reaction types were defined as a faulty response or an insufficient adjustment. Depression was categorised within the affective reaction types (Lawlor, 2013; Meyer, 1952). It was argued that a meticulous history of the individual's personal situation was needed, because if the causes of the symptoms could be analysed, then a way of developing an appropriate trajectory and cure could be established (Meyer, 1957).

Although it was Heinroth's (1818) and Meyer's (1905) contribution, that led to the adoption of the term depression for a category of illness that included melancholia, it was from Freud's 1917 essay "Mourning and Melancholia" that the term depression began to replace melancholia. This is because Freud used the terms depression and melancholia interchangeably. However, it was not until the second half of the 20th century that depression achieved its modern meaning and usage (Lawlor 2013). Freud characterised melancholia as "a profoundly painful dejection, cessation of interest in the outside world, loss of the capacity to love, inhibition of all activity and lowering of the self-regarding feelings" (1917, p. 545). This definition describes depression and differentiates it from mourning which was characterised as a "regular reaction to the loss of a loved person or the loss of some abstraction" (Freud 1917, p. 544).

The Second World War increased the influence of psychiatry in the general population. The apparent success in treating soldiers with mental illness after the war suggested that psychiatrists could help the general public. The war illuminated the effect of social factors and promulgated the belief that all people are potentially at risk of mental illness. Furthermore, in the 1950's more people became familiar with the work of psychiatrists due to popular magazines absorbing psychological vocabulary. This set the scene for the explosion of the mental health market in the second half of the twentieth century (Lawlor, 2013).

Freudian and Meyerian theories dominated ideas about depression until the 1970's. During this time disease categories and specific diagnosis were not necessary as the emphasis was on conflicts of the unconscious mind (Lawlor, 2013; Mayes and Horwitz, 2005). However, the psychiatric community came under pressure to provide a greater degree of certainty (Cooper, 1967; Lawlor, 2013). This coincided with major breakthroughs in psychopharmacology research (Lieberman, 2003). Burgeoning a reassessment of the Freudian and Meyerian consensus (Young, 1995).

Pharmaceutical success and a demand for more certainty in diagnosis led to the rebirth of Kraepelin's nosology (Lawlor, 2013; Young, 1995). Kraepelin's ideas regarding the need for diagnostic classification lead to statistical analysis of symptom clusters to identify different groups of patients and diseases; in institutional contexts and in community practice (Lewis, 1971; Lawlor, 2013). Feighner, Robins, Guze, Woodruff, Winokur and Munoz (1972) used patient symptoms as diagnostic criteria to eliminate the ambiguity and confusion around depression. Depression was considered a primary disorder of emotions. A diagnosis of depression required the patient to satisfy three criteria: (1) Dysphoric mood, (2) Five additional symptoms must be present (suicidal thinking, guilt, agitation, lack of: hunger, sleep, energy, interest in normal activities and speed of thought), (3) The symptoms must last one month (Feighner *et al* 1972). Feighner *et al* (1972) also defined the extent to which a patient fulfilled diagnostic criteria. This was coined the Feighner criteria. The Feighner criteria', was adapted by Spitzer *et al* (1978) as part of the Research Diagnostic Criteria (RDC). The RDC introduced the terms major depression (fulfilled diagnostic criteria) and minor depression (sub-threshold). Symptom duration was shortened from one month to two weeks, and loss of interest could replace dysphoric mood. The RDC also specified that sufferers should exhibit social disability. These diagnostic criteria were the first attempt at creating a diagnostic classification system. They have been adopted into the DSM, which is currently one of the leading classification systems in the western world (American Psychiatric Association, 1980). The diagnostic classification of depression will be discussed in section 1.2.

Overall it has been demonstrated that the way depression is understood and conceptualised varies throughout history and a universal conceptualisation of depression is absent (Kendell, 1995). This demonstrates a gap in the literature, an ambiguity around the concept of depression and that what counts as depression is determined by discourse. Despite the ambiguity around depression there is a growing body of research indicating that the ways in which clinicians conceptualise mental health, guides and informs their attitudes and reasoning. It also guides their approaches to assessment, formulation, intervention and evaluation (Harland *et al* 2009). Researchers have therefore suggested that clinicians' conceptualisations of mental health have significant clinical implications for their work with service users (Hugo, 2001; Stevens and Harper, 2007). This demonstrates that more research needs to explore how service users and therapists construct depression.

1.3 Diagnostic Classification of Depression:

Formal classification systems are a 20th century phenomenon (Gruenberg *et al* 2005). The aims of classification systems are to enhance communication between clinicians, improve understanding of disorders and promote effective and appropriate treatment (Gruenberg, *et al* 2005). Formal classification systems shape beliefs about mental disorders and subsequently shape the knowledge of clinicians and researchers who work in the field of mental health. Discourse, which determines the meaning of depression, has a significant impact on how practitioners, the media and laypersons construct and talk about depression (Crowe, 2000). Classification systems operate as a tool for separating "abnormal" behaviour from "normal" behaviour in society. Classification systems, impact the patient's future, as being given a label of depression and eligibility for treatment, both have long-term implications.

In the English-speaking world classification of depression is governed by two systems: Chapter V of the *International Classification of Diseases* (ICD), published by the World Health Organisation and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association. The DSM was developed for classification of mental disorders, whereas the ICD was developed to classify all diseases and to be used internationally. The DSM and ICD provide standard criteria for the classification of mental disorders and are used worldwide to guide patient diagnosis. The ICD is the official coding system in many countries. However, the DSM is more popular among mental health professionals in the UK.

1.3.1. Early Formal Classification Systems and The Crisis of Legitimacy in Psychiatry:

The diagnostic approach was first typified by the development of the ICD-6 published in 1948 and the DSM-I published in 1952 (Gruenberg *et al* 2005). The scientific integrity of DSM-I and DSM-II were questioned on the basis that they lacked reliability and validity, leading to type-1 and type-2 errors in diagnosis (Blashfield, 1998; Kirk and Kutchins, 1994). In DSM-II none of the diagnostic categories had uniformly high reliability, and diagnostic agreement among clinicians was low ranging between 10% -67% (Ash, 1949; Beck *et al* 1962; Sandifer *et al* 1964; Sandifer *et al* 1968).

Rosenhan's study 'Being Sane in Insane Places' (1973) increased concerns about the reliability and validity of the first two editions of the DSM, and about psychiatry/ psychology as a profession (Kirk and Kutchins, 1994; Double, 2002). In the study eight accomplices of the experimenter gained admission to twelve hospitals. Each accomplice presented with a single complaint; hearing voices that said, "empty, hollow and thud." On admission to the psychiatric ward the accomplices stopped simulating any symptom of abnormality. The average length of hospitalisation was 19 days and all the accomplices received a psychiatric diagnosis of schizophrenia (Rosenhan, 1973). Furthermore, they were all treated as 'insane' despite not having any mental health problems or symptoms. It was concluded that psychiatric diagnosis is subjective and does not reflect inherent patient characteristics. These concerns further demonstrate how the categories of mental health may not necessarily refer to real divisions, but are constructed through discourse. Although this study was about schizophrenia and not depression, it highlights a disagreement over what counts as mental health and depression. Therefore demonstrating how more research needs to be conducted around the construction of depression.

The DSM-II's nomenclature conceptualised depression within the psychodynamic and psychoanalytic paradigms. The increase in pharmaceutical success burgeoned the marginalisation of the previously dominant psychodynamic paradigm (Young, 1995). This led to the legitimacy of psychiatry to be questioned in the late 1960s and 1970s and an anti-psychiatry movement commenced (Cooper, 1967).

The anti-psychiatry movement was led by Szasz, Foucault and Laing. They claimed that psychiatry was a mode of social control rather than a genuine attempt to heal the ill, and regarded mental illness as a social phenomenon, acting as a 'social tranquiliser' to control nonconforming behaviour (Szasz, 1960; Foucault, 1965; Laing, 1967; Mayes and Horwitz, 2005). They advocated the concept that personal reality was independent from any hegemonic definition of normalcy imposed by organised psychiatry (Rissmiller and Rissmiller, 2006: 863). In *Madness and Civilization: A History of Insanity in the Age of Reason*, Foucault outlined the social context of mental illness and noted that external economic and cultural interests have always defined it. For example, during the Renaissance, mad men were characterised as fools who figured prominently in the writings of Shakespeare. Whereas in the 17th century, madmen and the poor were confined and locked away, as a condemnation of anyone unwilling or unable to compete for gainful employment (Rissmiller and Rissmiller, 2006: 863). Furthermore, Szasz

claimed the classification of schizophrenia as a disease was a fiction perpetrated by organised psychiatry to gain power. It was postulated that the state was using psychiatry as a way to exclude nonconformists legitimately, and argued for a division between state and psychiatry. The anti-psychiatry movement was also reflected in popular culture. Many of the critical arguments were expressed in Ken Kesey's novel (1962) and film (1975) *One Flew Over The Cuckoo's Nest* which expressed fears about the abuse of institutional psychiatric power. It was allied to the argument that mental illness was not real but a label used to coerce nonconformists (Mayes and Horwitz, 2005). Fear was also developing surrounding stigmatisation and self-fulfilling prophecies (Lawlor, 2012).

In reaction to the anti-psychiatry movement the DSM-III was published in 1980. It differed from previous classification systems in that diagnosis and symptomology became a central feature (Mayes and Horwitz, 2005; Goodwin and Guze, 1996). Whereas in DSM-I and DSM-II, diagnosis played a marginal role; as symptoms did not reveal disease entities but disguised underlying conflicts that could not be expressed directly. This change enabled standardised measurement; which improved reliability and enabled easier reimbursement from insurers (Gruenberg, Goldstein and Pincus, 2005; Mayes and Horwitz, 2005). The DSM-III also introduced the unitary concept of Major depression. Major depression could be classified as a single episode or recurrent; characterised by one or more major depressive episodes (See Appendix 1) and the absence of manic episodes (American Psychiatric Association, 1980). DSM-III also introduced a multi axial system, which enabled clinicians to focus attention on multiple domains of information during the evaluation process (Gruenberg *et al* 2005). Major depression was classified as an axis I disorder (American Psychiatric Association, 1980).

1.3.2. DSM-IV and ICD-10 Classification of Depression:

The DSM-IV was published in 1994; it maintained the multi axial system and diagnostic model from DSM-III (Gruenberg *et al* 2005). The major changes regarding depression involved the introduction of a nine criteria symptom list, for the classification of a depressive episode. To meet the diagnostic criteria, depressed mood or loss of interest and pleasure, must be present most of the day, nearly every day for a two-week period and four additional symptoms[1] must also be present (American Psychiatric Society,

[1] Change appetite or weight, Psychomotor agitation or retardation, Loss of energy, Feelings of worthlessness, guilt, diminished ability to think or concentrate, suicide ideation

1994). In DSM-IV the symptoms are required to cause clinically significant distress or impairment in social, occupational or other important areas of functioning (American Psychiatric Society, 1994). DSM-IV offered essential and additional features; presence, course and familial pattern, and differential diagnosis, age, gender and culture (Blashfield, 1998). The DSM-IV revised (DSM-IV-TR) published in 2000 was almost identical to DSM-IV (First and Pincus, 2002). The changes were limited to dialogue rather than symptomology. It emphasised client-centred speech. Phrases such as schizophrenic were removed and replaced with "an individual with schizophrenia" in an attempt to classify disorders not people (Blashfield, 1998; American Psychiatric Society, 2000).

The description of a depressive episode in ICD-10 (2003) involved a narrative paragraph with less specific criteria for diagnosis; compared with the list of criteria in DSM-IV-TR. The ICD-10, groups items into two sets. One containing three items; depressed mood, loss of interest and decreased energy and the other set contains seven additional symptoms[2] (World Health Organisation, 2003; First, 2009). The severity of the episode represents a distinct syndrome as opposed to a modifier in DSM-IV (Gruenberg *et al* 2005). For a mild depressive episode; two or three of the symptoms must be present, for a moderate depressive episode four or more symptoms must be present and for a severe depressive episode several symptoms must be present (World Health Organisation, 2003). Special significance is given to three of the symptoms: depressed mood, loss of interest and decreased energy. It is required that two out of the three symptoms are present for mild and moderate depressive episodes and three out of three for severe depressive episodes (First, 2007; World Health Organisation, 2003).

1.3.3. The Differences Between DSM-IV-TR and ICD-10:

The DSM-IV-TR and the ICD-10 have eight symptoms in common within their definition of depressive episode: depressed mood, loss of interest, decreased energy/increased fatigability, recurrent thoughts of death/suicidal behaviour, inability to concentrate/indecisiveness, psychomotor agitation or retardation, sleep disturbance and change in appetite or weight. They differ on the remaining items. ICD-10 has two

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[2] reduced concentration and attention; reduced self-esteem and self-confidence; ideas of guilt and unworthiness (even in a mild type of episode); bleak and pessimistic views of the future; ideas or acts of self-harm or suicide; disturbed sleep; diminished appetite

additional symptoms: loss of confidence or self-esteem and inappropriate or excessive guilt. The DSM-IV-TR has one additional symptom; inappropriate or excessive guilt with feelings of worthlessness (First, 2007).

The structure of the two diagnostic systems also differs. The DSM-IV-TR presents nine items in one set; specifying depressed mood or loss of interest must be present for a diagnosis of major depressive episode. The diagnostic threshold in ICD-10 is specified in terms of the number of symptoms present, from both sets of symptoms (American Psychiatric Association, 2003; First, 2007; World Health Organisation, 2010). The ICD-10 provides separate diagnostic thresholds for each of the different severity levels; mild, moderate and severe. Severity specifiers in the DSM are only assigned after the threshold for a major depressive episode has been reached. Severity is based on how many symptoms are present in excess of the threshold, combined with the level of functional impairment (American Psychiatric Association, 2003; First, 2007; World Health Organisation, 2010).

On the surface these differences appear minor. The ICD-10 and DSM-IV-TR share eight symptoms, suggesting that overlap in diagnosis would be present. However, there are cases where diagnosis would differ between the two classification systems (First, 2007; Gruenberg *et al* 2005). Examples of where individuals would meet the diagnostic criteria for a depressive episode under the ICD-10 criteria, but not under the DSM-IV-TR criteria, include: Depressive episodes with a total of four symptoms, as five symptoms are the minimum required for a diagnosis in DSM-IV-TR. A mild depressive episode with five depressive symptoms, of which loss of confidence or self-esteem is one of the symptoms, as the DSM-IV-TR does not specify loss of confidence or self-esteem as a symptom (First, 2007). An example of where individuals would meet the diagnostic criteria for a depressive episode under the DSM-IV-TR, but not under the ICD-10 would be; a major depressive episode with depressed mood and four symptoms other than loss of interest or decreased energy, as this would violate the ICD-10 requirement for two out of the three defining symptoms to be present (First, 2007).

The lack of consensus between DSM-IV-TR and ICD-10 has implications for academia and clinical practice. Small differences in diagnostic criteria can lead to significant rates of diagnostic discordance (25%-50% diagnostic discordance rate) (First, 2009; Saito *et al* 2013; Faravelli *et al* 1996; Vilalta-Franch *et al* 2006; Turkcapar *et al* 1999, Paykel, 2002; Lopez-Ibor *et al* 1994). Discrepancies between DSM-IV-TR and ICD-10, impedes

the capacity to reliably define diagnostic samples for research; producing variability in the prevalence rates of depression and inconsistencies and contradictions in clinical trial and pharmaceutical research (Andrews *et al* 1999; First, 2009; Saito *et al* 2010). Differing diagnostic boundaries has implications within clinical practice, as some individuals with depression may not receive adequate treatment. Discordance between classification systems could also cause false-positives (Cooper, 2013). False-positives lead to individuals without disorders being labelled with a psychiatric diagnosis causing unnecessary stigmatisation and antidepressant medicalisation.

This discordance highlights how to date there is not a unifying conceptualisation of depression. This emphasises the need for more research regarding what depression is and its implications for individuals with a diagnosis of depression and clinicians.

1.3.4. The DSM-5 and Depression:

The core criteria symptoms and the requisite symptom duration of two weeks have not changed from DSM-IV-TR to DSM-5. The major change from DSM-IV-TR to DSM-5 is the omission of the bereavement exclusion. In DSM-5 a depressive episode can be diagnosed two weeks after bereavement. This attempts to harmonise the DSM-5 with ICD-10. It has also been suggested that it will provide more individuals with access to effective treatments (Kendler *et al* 2008).

The key motives for eliminating the bereavement exclusion included the premise that bereavement-related depression is associated with similar symptom profiles and risk of recurrence as non-bereavement related depression (American Psychiatric Society, 2013). However, contradictory research identified that the risk of recurrent depression in individuals experiencing grief, does not differ from that of healthy controls (Wakefield, 2012; Wakefield and Schmitz, 2013a). A further reason the American Psychiatric Society gave for the omission of the bereavement exclusion is that depressive symptoms associated with bereavement-related depression respond to anti-depressant treatment (American Psychiatric Society, 2013). However, there is no evidence that individuals with bereavement related depressive episodes benefit from antidepressants (Wakefield and Schmitz, 2013b). Increased suicide risk has been stated as another rationale for eliminating the bereavement exclusion from DSM-5 (American Psychiatric Society, 2013). The rational for this claim is flawed because the DSM-IV

bereavement exclusion required there to be no suicidal ideation to protect against excluding suicidal patients. Therefore, any individual presenting with suicidal ideation would be classified as experiencing a "complicated" depressive reaction during grief, and a diagnosis of major depressive episode would be given; despite the recent bereavement.

Diagnostic manuals such as the DSM play a fundamental role in shaping the media and laypersons perceptions of mental disorders and 'normality'. By placing a time frame on recovery from grief (two weeks), the DSM-5 is moving further away from a person centred approach. This is because the change in the diagnostic prominence of grief from bereavement (not a mental disorder) to depression (a mental disorder) could lead to false positives e.g. individuals without disorders being gratuitously exposed to a label of a psychiatric diagnosis.

1.3.5. Synthesis:

The differences between each edition of the DSM and ICD reflect the changes in psychiatric understanding and conceptualisation of depression. The first editions relate to psychodynamic psychiatry; constructing depression as the result of the unconscious translating anxiety about loss or an internal conflict (Lawlor, 2012). While later editions reflect a biological approach to psychiatry; implicating neurotransmitter dysfunction as a possible evidence of depression. The differences between formal classification systems highlight how to date there is not one unifying classification of depression and that what counts as depression is determined by discourse. Therefore, there is disagreement over what counts as depression, so researchers need to look at how depression is constructed. The next section will discuss the cognitive paradigms of depression and how this paradigm conceptualises depression.

1.4 The Aetiology of Depression:

The first part of chapter one gave an overview of the psychological and psychiatric conceptualisations of depression throughout history. It demonstrated that the way depression is understood and conceptualised has varied throughout history and within formal classification, therefore highlighting that a widely accepted conceptualisation of depression is absent from the literature. This has clinical implications for mental health

professionals and lay individuals and highlights the need for research that examines how depression and individuals with a diagnosis of depression are conceptualised. Considering current causal explanations for depression is important for understanding how depression is conceptualised and current treatment options. Since the 1980's the bio-psycho-social model of depression (Engel, 1978) has risen in prominence and is the dominant ideology of mainstream psychiatry today (Davies, 2016: 14). It was developed in response to the purely biomedical view of depression dominating in the early twentieth century (Hatala, 2012). The bio-psycho-social model promotes a holistic view of the person's distress and considers three aspects as central to the management of depression: biological, psychological and social. The model conceptualises these three areas as separate parts of a whole that interact and influence each other (Davies, 2016: 15).

However, research into the biological causes of depression is still a large area of study. In October 2015, $525 million was invested on research into depression, primarily investigating its genetic, molecular and chemical causes (Sullivan, 2015). Also, biological models of depression, especially the chemical imbalance theory, have been highly promoted (Leo and Lacasse, 2008) and became the dominant construction of depression in media articles about depression in the 2000s (Clarke and Gawley, 2009). A 2008 cross-sectional study (Budd, James and Hughes, 2008) undertaken with the general public in the UK to examine lay individuals attitudes to the development of depression, found that a 'chemical imbalance in the brain' was rated only behind the bereavement of an immediate family member. However, another UK study showed that although people may be increasingly endorsing a biological viewpoint, they still endorse psychosocial causes of depression (such as work or life stressors) (Lauber, Falcato, Nordt, and Rossler, 2003). An alternative way of conceptualising depression is the 'psychosocial' viewpoint (Conrad, 2008). A systematic review of the research conducted in 2014 (Hagmayer and Engelmann, 2014) found that in western countries, depression due to environmental factors was considered to be the most endorsed cause of depression, followed by biological causes.

Interventions for depression reflect the changing views on the causes of depression. As the prevalence of biological causal beliefs has increased, prescriptions for antidepressants have also increased. In England, prescribing rates of anti-depressants have increased by 165% since 1998 (The Health Foundation, 2014), and most clinical guidelines recommend intervention with medication (APA, 2010). However, in 2007 the

UK Government announced an unprecedented, large-scale initiative for Improving Access to Psychological Therapies (IAPT) for depression and anxiety disorders within the English National Health Service (NHS) (Clark *et al* 2009). The IAPT service predominantly offers Cognitive Behavioural Therapy (CBT) for depression and anxiety, as recommended by the National Institute for Clinical Excellence (NICE) (Clark *et al* 2009). Currently over 500,000 individuals receive CBT treatment via IAPT each year, thus making CBT one of the leading treatments for depression in the UK (Gratzer and Goldbloom, 2016). Therefore the following section gives an overview of how the cognitive behavioural paradigm conceptualises and understands depression. It aims to give a brief overview of the origins of CBT, the cognitive model of depression and CBT strategies and mechanisms for change. For a more detailed overview of CBT see Beck (1976) *Cognitive Therapy and The Emotional Disorders* and Beck's (1964) *Thinking and Depression – Theory and Therapy*.

1.5 The Cognitive Behavioural Paradigm and Depression:

1.5.1. Origins of Cognitive Behavioural Therapy (CBT):

Aaron Beck founded CBT in 1963, through clinical observations and experimental testing (Beck, 1963; 1964). The cognitive behavioural paradigm centres on the relationship between thoughts, emotions, physical symptoms, behaviour and environment, which make up human experience. It emphasises the central role of thoughts and thought processing (Kingdon and Dimech, 2008). It is assumed that a change in cognition will induce changes in all the other elements of human experience (Greenberger and Padesky, 1995).

"Men are disturbed not by things but by the view which they take of them" (Epictetus, 135)

The philosophical origins of CBT can be traced back to Greek Stoic philosophy. Epictetus in (135), observed that people are not disturbed by events but by their views of such events. Similar to Stoicism, Eastern philosophies such as Taoism and Buddhism, emphasised that people's emotions are based on ideas and the control of emotion is achieved by changing ones' ideas (Beck *et al* 1979). Even Shakespeare orients to the fundamentals of CBT in Hamlet suggesting *"For there is nothing either good or bad, but thinking makes it so"* (Hamlet, Act 2, Scene 2). The founder of CBT, Beck (1991), asserts that the cognitive model is both a derivative of and reaction against psychoanalysis. CBT

embraces the emphasis on meanings and generalised reaction patterns, but rejects the importance of the unconscious and psychosexual stages. Instead Beck postulated that individuals' thoughts regulate their emotions and behaviours (Beck, 1962 cited in Gilbert and Leahy, 2007).

The CBT model is influenced by, Kant, Heidegger and Husserl's phenomenological movement at the end of the 20th century. The behaviourists Pavlov, Thorndike and Watson's research on animal learning; reinforcement and behaviour; and principles to induce anxiety responses also influenced the development of CBT. The integration of cognitive and behavioural approaches stems from Bandura's work on the contribution of cognitive factors in observational learning (Hawton *et al* 1989; Gilbert and Leahy, 2007). In the mid 19th century there was a burgeoning of cognitive therapeutic paradigms, as alternatives to behaviourist and psychodynamic theories. Within this timeframe CBT, Personal construct therapy (PCT) and Rational Emotive Behaviour Therapy (REBT) were concurrently developed (Kelly, 1955; Ellis, 1957; Ellis, 1962). All of these therapeutic paradigms emphasise the cognitive process and its role in depression acquisition and maintenance. For a review of the key differences see Ellis (1980) and SUE, (1999).

1.5.2. The Cognitive Model of Depression:

The Cognitive model of depression maintains that an individual's affect and behaviour are determined by the way the individual perceives and structures the world (their cognitions) (Weishaar and Beck, 1986). Cognitions are founded on attitudes or assumptions, developed from previous experiences (Weishaar and Beck, 1986). Beck's (1967; 1976) Cognitive Model of Depression is illustrated below (Figure 1).

Beck's cognitive model of depression (Figure 1), suggests that experiences lead people to form assumptions or schemata about themselves and the world. The development of schemas is part of normal cognitive development and enables individuals to organise and The Cognitive model of depression maintains that an individual's affect and behaviour are determined by the way the individual perceives and structures the world (their cognitions) (Weishaar and Beck, 1986). Cognitions are founded on attitudes or assumptions, developed from previous experiences (Weishaar and Beck, 1986). Beck's (1967; 1976) Cognitive Model of Depression is illustrated below (Figure 1). Beck's cognitive model of depression (Figure 1), suggests that experiences lead people to form

assumptions or schemata about themselves and the world. The development of schemas is part of normal cognitive development and enables individuals to organise and evaluate the world (Padesky, 1994). The ability to make sense of experiences is useful and necessary for 'normal' cognitive functioning (Hawton *et al* 1989). However, some assumptions are rigid, extreme and resistant to change. These assumptions are referred to as dysfunctional beliefs or schemas.

Figure 1: Beck's Cognitive Model of Depression (Beck, 1967)

The specific content of these beliefs are referred to as core beliefs (Beck, 1995). Dysfunctional beliefs serve as diathesis for the occurrence of depression. Therefore, depression is established by negative beliefs, rather than having these negative beliefs because of depression. However, dysfunctional beliefs do not singularly account for the development of depression. Depression arises when critical incidents occur which align or support the individual's dysfunctional beliefs. For example a core dysfunctional belief that personal worth is dependent upon work or financial success could lead to depression in the event of failure, job loss or financial loss (Hawton *et al* 1989). Once dysfunctional beliefs are activated by a critical incident negative automatic thoughts (NAT) are produced. NAT's are immediate, quick, first, thoughts or images that are generated in response to a situation. NAT's are referred to as negative because they are associated with unpleasant emotions and automatic because they are generated involuntarily without deliberate reasoning (Curwen *et al* 2000; Hawton *et al* 1989). NATs lead to behavioural (e.g. withdrawal), motivational (e.g. apathy), emotional (e.g. anxiety, guilt), cognitive (e.g. poor concentration) and physical (e.g. appetite or sleep) symptoms of depression.

The central feature of the CBT model of depression is the role of thoughts and cognitive processing (Kingdon and Dimech, 2008). Beck suggested that depressive thoughts could

be characterised in terms of the cognitive triad. The cognitive triad, consist of negative beliefs about the self (e.g. I'm a failure) the world (e.g. the world is unfair) and the future (e.g. everything will turn out badly) (Williams, 1984; Young and Beck, 2001). Related to the cognitive triad, individuals with depression are posited to exhibit cognitive distortions which maintain their negative beliefs and lead to maladaptive interpretations of events (Beck, 1979). These are often referred to as cognitive errors. Cognitive distortions or bias can occur across all levels of functioning (Beck *et al* 1979). On the level of automatic thoughts, cognitive distortions are referred to as thinking errors (Beck *et al* 1979). The most common thinking errors for depression include: *Polar Reasoning* (all or nothing thinking), whereby a slight waiver from perfection is considered failure; *Abstraction,* here successes are ignored; and *Overgeneralisation,* whereby a failing in one area implies future failure in all other related things (Curwen *et al* 2000). These errors maintain and increase the validity of negative beliefs despite the presence of contradictory evidence (Beck, 1979). Thinking errors are the result of faulty information processing and problematic schemas. Problematic schemas are cognitive distortions on the deepest level of cognition and are often referred to as maladaptive schemas or Depressogenic Schemas. Depressogenic schemas are formed from early experiences. They form the foundation or system by which an individual classifies and interprets information and experiences in a meaningful way, about them self and the world (Young, 1999). They tend to be general, long lasting, overgeneralised and have a self-perpetuating quality (Curwen *et al* 2000). As a result, they lead to significant psychological distress in a recurring manner. Beck (1995) suggested there are two main categories of maladaptive schemas: those related to helplessness and those related to un-lovability.

1.5.3. Therapeutic Strategies and Mechanisms of Change:

An understanding of the therapeutic process is important because the current thesis aims to discursively examine therapeutic interactions during CBT sessions. Therefore, the following section provides a brief overview of a CBT session and its therapeutic aims.

Cognitive therapy is "an active, directive, time-limited, structured approach … based on an underlying theoretical rational that an individual's affect and behaviour are largely determined by the way in which they structure the world" (Beck *et al* 1979: 3). CBT is

based on the cognitive model of emotional disturbance outlined above. It can be conceptualised as a type of problem solving because it is problem oriented and focused on the here and now, rather than the origins of problems (Hawton, 1989). The goal of CBT is to find solutions to the service users problems using cognitive-behavioural strategies. Within CBT the service user is identified as an equal partner and is encouraged to develop independent self-help skills through a process of questioning and guided discovery. The service user learns to view their thoughts and beliefs as hypotheses and to test their validity. Cognitive behavioural techniques are presented as skills to be acquired via practice. It is a short-term intervention delivered over a finite number of sessions (8 to 20 one-hour sessions) (Hawton, 1989). CBT sessions tend to follow the pattern outlined in Table 1. Termination of therapy is pre-planned although bolster sessions can be offered.

1.5.4.1 Major Cognitive Behavioural Therapy Strategies:

Research suggests that the acquisition of mood management strategies is an important factor for symptom reduction and CBT effectiveness (Hundt, *et al* 2013; Strunk *et al* 2014). These strategies include, but are not limited to, behavioural activation (BA), cognitive restructuring (CR), and core belief (CB) strategies (Hawley *et al* 2016).

In the preliminary sessions of CBT, Behavioural Activation (BA), strategies are introduced. BA strategies enable service users to examine the relationship between their behaviours and affect, to maximise the service user's engagement in mood elevating activities (Martell, Addis, and Jacobson, 2001). BA strategies include: monitoring activities (recording levels of activity and mood), scheduling activities (plan each day to increase activity levels) and graded task assignment (breaking tasks down into small manageable steps) (Hawton *et al* 1989). The increased frequency of BA skill use has been found to correlate with lower post-treatment depression scores (Jarrett *et al* 2001; Christopher *et al* 2009; Hunter *et al* 2002; Neuhaus *et al* 2007; Rees *et al* 2005).

After service users have engaged with BA strategies, the next stage of CBT treatment involves acquiring Cognitive Restructuring (CR) strategies. CR strategies involve evaluating NATs; they are used to reduce depressive symptomology and tackle 'life problems'. First the service user identifies NATs with the therapist through self-monitoring techniques such as thought records. Thought records are used to identify the

unpleasant emotion, the problem situation and associated negative automatic thought. The service user and therapist then test the NAT by examining evidence for and against it. They evaluate the advantages and disadvantages in order to generate a more balanced way of thinking. This is usually followed by behavioural experiments that aim to enhance the credibility of this new way of thinking (Hawley *et al* 2016; Hawton *et al* 1989). Greater frequency of CR skill use has been found to predict lower depression scores at the end of treatment (Jacob *et al* 2011). This suggests that a central mechanism for therapeutic change in CBT involves the acquisition of cognitive skills to deal more effectively with stressful life events (Barber and DeRubeis, 2001).

Table 1: The Structure of a CBT Session

1. Set the agenda: Deciding what to work on in the session

2. *Weekly items:*

- Review of events – brief discussion of how things have gone since previous session allowing any relevant incidents to be brought to light.
- Feedback on previous session –reflections and learning from the last session
- Homework review – to identify outcomes and difficulties and reinforce independent functioning

3. *The day's major topics:* (this is the majority of the session time)

- Specific strategies
- Specific problems
- Long-term problems

If several topics are important the service user is asked to list topics in order of priority

4. *Homework assignments:* Self help assignments to be carried out between sessions

- Task – what is the homework assignment?
- Rationale – what is the task designed to achieve?
- Predicted difficulties – to help overcome the service users perceived difficulties with the task

5. *Feedback:*

- Understanding – service user is asked to summarise what they have learnt
- Reactions – how does the service user feel about the session, has anything upset or offended them

In the final phase of CBT treatment, Core Belief (CB) or schema strategies are used to identify, challenge and modify dysfunctional beliefs about the self, world and future. These strategies aim to undermine the fundamental assumptions on which depressive thinking is based. CB interventions include developing an alternative case formulation, cognitive restructuring (via use of the continuum technique), core belief logs and historical reviews (Padesky, 1994). Research suggests CB strategies are effective at reducing the risk of relapse for depression because core beliefs play a large role in the onset and maintenance of depression (Blatt, 2004; Hawley *et al* 2006).

1.5.4. Critical Responses to Cognitive Behavioural Therapy:

In CBT theory the emphasis is placed on collaboratively challenging the links between thinking, feeling and acting. These assertions regarding the service users' faulty thinking might be effective for someone experiencing mild depression. However, challenging an individual's faulty thinking could be experienced as critical, disrespectful or un-empathetic in oncology patients, palliative care settings or when working with individuals who have experienced loss or trauma. For example, thinking errors about the self (e.g. I'm a failure) the world (e.g. the world is unfair) and the future (e.g. everything will turn out badly), might not be cognitive errors but logical rational thoughts when faced with the possibility of death or after experiencing trauma. Challenging these thoughts could be counterproductive in these circumstances.

Critical responses to CBT can also be found in media coverage and academic literature. It regards the CBT approach as naive and simplistic in its premises about human suffering (Pilgrim, 2011; Hope, 2008; Leader, 2008). CBT provides a model of learning but takes little account of early development and its effects upon psychological structures (Ryle, 2012). In CBT theory the emphasis is placed on the description and challenging the links between thinking, feeling and acting. The therapists' positive responses to more effective behaviours may be reinforcing but in the case of persistent negative behaviours, especially when these undermine therapy, there is little theoretical understanding of what to do. In such cases CBT therapists rely upon their personal qualities and service user compliance to maintain the therapeutic work (Ryle, 2012). There are concerns that CBT (as the name implies) only addresses a specified range of psychological processes. Cognitive processes cannot stand equivalent to all psychological processes (Cristea and Cuijpers, 2017). Furthermore, CBT's ideology has

also been critiqued by psychoanalysts stating approaches like CBT 'fail to provide the relief that is being deeply looked for' (Casement, 2009). It is argued that service users require time for 'an enduring resolution to their inner conflicts', not the 'superficial solutions' imposed from CBT externally. Casement (2009) suggested that for psychoanalysis we are all ill to some degree, whereas for CBT only some people are ill (and they can be cured if they are obedient patients)(Casement, 2009). Although CBT has been shown to be superior to medication treatment for the symptoms of depression and anxiety (Gilbert, 2009), Wampold *et al* (2017) conducted a meta-analysis regarding CBT's effectiveness and did not find added benefits of CBT over other psychotherapies. The question of 'What makes psychotherapy work?' is noted by Kazdin (2009: 418), as the 'most pressing question, but one with few answers'. This suggests that we do not know why or how therapies achieve therapeutic change. The requisite research to answer the question is rarely done, and fresh approaches such as discursive examinations of how CBT accomplishes its therapeutic aim are needed.

1.6 Summary of Chapter One:

Chapter one has diachronically reviewed how depression has been constructed and understood, and highlighted the changes the term depression has undergone overtime. This demonstrates that the conceptualisation of depression is a discursive process. Therefore research needs to be conducted around how depression is constructed. Chapter one also reviewed how formal classification systems have conceptualised depression. It demonstrated how main classification systems have changed overtime and that the DSM and ICD, differ in their classification of depression. The lack of concordance between the DSM and ICD suggests that a single universal definition of depression does not currently exist, and that the categories 'depressed or non-depressed' may not necessarily refer to real divisions. This highlights that there are currently limitations regarding how depression is understood that must be overcome to determine how depression is conceptualised. This is because a lack of a universal definition of depression could have implications for service users and therapists. The chapter concluded by examining how the cognitive model conceptualises depression, the aims of CBT and how a typical CBT session is structured. An understanding of CBT and the cognitive model of depression are important because the data analysed in this thesis consists of CBT sessions.

Chapter Two: How Lay Individuals Talk About Depression - Representations of Depression in the Western World:

2.1 Overview:

Chapter one reviewed how psychology and psychiatry conceptualise depression. It also illustrated that the way depression is understood and talked about, varies throughout history and also varies in the formal classification of depression. Thus, what counts as depression is determined by discourse. Therefore, chapter one demonstrated that the categories 'depressed or non-depressed' do not necessarily refer to real divisions, and that the literature lacks a universal definition of depression. This emphasises that the conceptualisation of depression is a discursive process. Given the variability of how psychology and psychiatry have conceptualised depression, chapter two will review qualitative literature regarding how lay individuals conceptualise depression. Although there is a large body of literature that quantitatively examines the aetiology (see Shader, 2014 for a review), prevalence (see Spiers, 2016, for a review) and treatment outcomes and efficacy (see Van and Spijker, 2008, for a review) of depression, the exclusive focus on qualitative research means this quantitative literature is not reviewed here.

2.2 Increased Use of Negative Language:

It is a well-established notion that individuals with a diagnosis of depression have relatively negative perspectives (Beck, 1967; Hamilton and Abramson, 1983; Hollon, Kendall and Lumry, 1986; Krantz and Rude, 1984; Rude *et al* 2004; Rude, Krantz and Rosenhan, 1988). Therefore, it is to be expected that a number of content analysis studies have demonstrated that individuals with a diagnosis of depression have a tendency to engage in negative verbal behaviour. A content analysis revealed that depressed psychiatric inpatients used significantly more negatively charged words than non-depressed surgical inpatients (Hinchliffe, Lancashire and Roberts, 1971). This tendency to engage in negative verbal behaviour has been found when analysing marital and maternal interactions. Individuals with and without a diagnosis of depression and their spouses engaged in 15-minute videotaped interactions. The videotapes were subsequently analysed via content analysis and scored for positive and negative verbal behaviour. Compared with non-depressed couples, the depressed couples emitted a lower proportion of positive verbal behaviour and a greater proportion of negative verbal behaviour during the interactions (Ruscher and Gotlib, 1988). Hamilton *et al*

(1993) examined mothers' verbal behaviour when communicating with their children. The verbal behaviour of mothers with unipolar depression, bipolar disorder, chronic physical illness and normal controls were compared. The unipolar depressed mothers were more likely to engage in negative verbal behaviour than any other maternal group. However these studies do not specify what constitutes non-verbal behaviour or what this non-verbal behaviour accomplishes.

However, when analysing the word usage in written discourse the tendency for individuals to use increased negative language was not as apparent. Sterman and Pennebacker (2001) analysed word usage in poetry of depressed and non-depressed poets and found the groups did not differ in their use of negative or positive emotion words. Furthermore, an analysis of depressed, formally depressed and never depressed student essays, revealed no significant difference in the use of negative or positive words (Rude *et al* 2004). These results suggest that familiarity between the depressed speaker and their conversational partner might be an important factor for verbal negativity to occur. Segrin and Flora (1998) conducted a content analysis to examine depressed and non-depressed student's conversational discourse with a stranger or friend. The individuals with depression, who talked with a friend, exhibited more negative language than other participants. These mixed findings suggest that situational factors, such as the familiarity of the conversational partner, may influence the tendency to engage in negative verbal behaviour.

2.3 Borrowed Terminology:

Considering depression as something external and beyond individuals' control is a common feature of discourse amongst individuals with a diagnosis of depression. Shaw (2002) accounted for this talking style by arguing that lay individuals are inundated with biomedical and psychological discourse through the media and interactions with clinicians. Support for this claim comes from narrative and content analyses, which have found that when individuals talk about depression they frequently borrow terminology from psychological and medical discourse (Kokanovic *et al* 2013; Yardley, 1997; Willig, 2000; Woollett and Marshall, 1997). In a study by Kangas (2001) in-depth interviews with depressed Finnish individuals were analysed. It was found that when talking about depression, individuals with a diagnosis of depression often used terminology borrowed from both biomedical and psychodynamic discourse. For example relationship with parents, lack of love and neglect were typical examples of the type of psychodynamic

discourse borrowed. Participants also used terminology such as "My neurotransmitters don't function" and "It's in the genes" when talking about their depression (Kangas, 2001). This finding also occurs across cultural groups within America. A content analysis of qualitative interviews with individuals with depression found that 86% of the European American participants, 60% of the African American participants and 56% of the Hispanic American participants used psychiatric terminology to describe their depression (Karasz, Garcia and Ferri, 2009). However, this study is not representative of wider cultural groups.

It is not known if the participants used in these studies had sought professional help for their depression. If so, then the use of borrowed terminology might be due to increased acculturation to professional representations of depression. Therefore, medical professionals might be structuring the lay-persons' representation of depression (Skultans, 2003).

2.4 Describing Depression/ Metaphors:

In conjunction with using borrowed terminology to conceptualise depression, individuals with depression often use metaphors to help communicate their experience of depression (Khan, Bower and Rogers, 2007). Metaphors used to describe depression include being 'on edge', 'churned-up inside', 'boxed in', 'a volcano bursting', 'broken in half', 'shut in my own little shell', 'a wall of pain' and 'prisoner in my own home' (Kadam *et al* 2001). These metaphors convey a sense of struggle and position depression as a threat.

Depression was frequently depicted as an "enemy" and as "paralysing", suffocating and even "destroying" the person. Furthermore, when individuals described overcoming depression they used metaphors such as 'fight', 'battle' and 'conquer'. These metaphors again position depression as a threat and something separate from themselves (Glasman *et al* 2004). These conceptualisations of depression convey the tormenting and isolating nature of depression.

2.5 More Frequent use of First Person Pronouns:

A series of studies have attempted to use content analysis as a diagnostic tool for psychiatric disorders. It was demonstrated that computerised linguistic analysis of

speech samples were capable of reliably and accurately classifying patients back into their appropriate diagnostic groups; such as schizophrenia, depression, paranoia, or somatisation disorder (e.g., Tucker and Rosenberg, 1975, Oxman *et al* 1982; 1988). When the diagnosis from a clinician was compared against a computer generated diagnosis, the computer diagnosis emerged as more accurate (Oxman *et al* 1988). These results indicate that language use could reveal important indicators or markers relating to peoples' state of mental wellbeing.

Studies examining word usage amongst individuals with or without a diagnosis of depression, commonly found that the individuals with depression used more first-person singular (I, me, my) words. Stirman and Pennebacker (2001) provide evidence consistent with this phenomenon. They examined the word usage in suicidal and non-suicidal poets (although depression was not measured directly in this study, it was inferred that the suicidal poets were more depressed than the non-suicidal poets). The suicidal poets used more first person singular (I, me, my) words and fewer words pertaining to the social collective (we, us, our). As depression was not directly measured it is not clear whether the findings are due to the poets' suicidality or depression or both because the suicidal thoughts are often comorbid with depression. However, elevated use of first-person singular words has been found in depressed older-adult female participants; when verbal data (a five minute monologue) was collected and compared to non-depressed older adults, undergraduates and non-depressed participants with schizophrenia (Bucci and Freedman, 1981). Similarly, it was found that when depressed participants were asked to talk about any personal topic for 10 minutes, they used "I" at a higher rate than the non-depressed participants (Weintraub, 1981). Furthermore, currently depressed students compared with never depressed students used significantly more first person singular pronouns in their personal essays (Rude *et al* 2002). This linguistic self-focus in depression, was further demonstrated by Rude, Gortner and Pennebaker (2004). They analysed essays written by currently depressed, formerly depressed and never depressed college students using linguistic inquiry and word count. The depressed participants used the word "I" more than the never-depressed participants. Whereas the formerly depressed participants' use of the word "I" increased across the essay and was significantly greater than the never-depressed writers in the final portion of the essay.

Despite the sometimes ambiguous clinical inclusion criteria, language use appears to be a subtle diagnostic marker. It has now been demonstrated that depression could be

characterised by a high degree of self-preoccupation and more frequent use of first person pronouns (Pennebaker, Mehl and Niederhoffer, 2003; Rude, Gortner and Pennebaker, 2004). However as depression was not measured directly in these studies future research should be more rigorous in specifying clear clinical inclusion and exclusion criteria, to allow inferences about the uniqueness of word use patterns in depressed versus non-depressed populations.

This evidence suggests that individuals with a diagnosis of depression have a proclivity to engage in self-focus; a tendency to construct events and situations in terms of themselves (Pyczsinski and Greenberg, 1987; Rude *et al* 2004). However, when responding to structured interview questions about depression and its causes, two dominant linguistic styles were noted. The styles included either use of the "I" form—for example, the story was told in the first person, or a more detached form of talk about "it"—for example, talking about depression as an external condition (Kokanovic *et al* 2013). The individuals with a diagnosis of depression who were still exploring explanations for their depression were more likely to associate the concept of depression with themselves, and use "I" when describing the phenomenon. Conversely, individuals who had explanations for their depression, tended to consider depression as something external and beyond their self-world (Kokanovic *et al* 2013). This literature provides an insight into the ways individuals with a diagnosis of depression talk. However, a more detailed understanding of this talk is needed to understand what self-focused talk accomplishes and what factors influence individuals' talk.

2.6 "I am Depressed" versus "I Have Depression":

2.6.1. Depressed and Depression:

One of the most prominent facets of how individuals talk about depression is their use of the word, "depression" or "depressed". Linguistic examination of how individuals talk about depression has found that individuals frequently situate their accounts of depression around two reoccurring constructs: "I am depressed" and "I have depression". Although the words depressed and depression both originate from the same lexical root (depress), they possess different lexicogrammatical characteristics (Harvey, 2012: 361). For example, in the context of personal disclosure, *depression* as a noun, can follow the 'possessive auxiliary' (I have depression) and the lexical verb suffer (I suffer from depression). While the participial adjective *depressed* can follow the

substantive verb (I am depressed) or the lexical verb feel (I feel depressed) (Harvey, 2012: 361).

Lexicogrammatical preferences are important as they translate a particular version of events and impact on how identity and the experience of depression are constructed and understood. The constructs "I have depression" and "I am depressed" represent two ways of characterising experience; that of "being" and that of "having" (Fromm, 1979). These facets of discourse indicate how individuals situate themselves in relation to their illness; revealing potential illness explanations and self-labelling positions (Estroff *et al* 1991: 339).

2.6.2. Having versus Being:

Linguistic examination via content analysis and thematic analysis has found that the statement "I am depressed" is often used to portray depression as a reaction to negative life events (De Shazer, 1997; Harvey, 2012). De Shazer (1997: 138) observed that the statement "I am depressed" is analogous to exclaiming "Ouch" after stubbing your toe in the dark. "I am depressed" is therefore akin to an expression and not a statement of knowledge, which can be right or wrong. Furthermore, the term depressed is often used nonchalantly as a blanket expression; applied to a variety of emotional states, which can be viewed as 'normal' and pathological (Leader, 2007: 7; Lewis, 1993).

A corpus linguistic analysis of adolescent health emails sent to the website Teenage Health Freak (www.teenagehealthfreak.org), examined how adolescents communicate psychological distress (specifically depression) to health professionals (Harvey, 2012). The individuals who stated "being depressed" in their emails did not seek medical advice from the health professionals. Instead they sought practical and social instruction with questions such as: "How do I deal with bereavement?", "What do I do about my family problems?", "How can I get a girlfriend?" and "What can I do about my appearance?". Harvey (2012) concluded from this that the state of being depressed is therefore not something that happens without reason. Being "depressed" is portrayed by individuals as an outcome of adverse circumstances; in particular the difficulty of coping with the pressures of fraught but not uncommon life events.

Other linguistic examinations found that individuals with a formal diagnosis of depression portrayed the experience of "being" depressed as an impermeable state; that

is dependent on changeable social context (Cornford *et al* 2007). The portrayal of depression as a reaction to negative life events creates a "victim discourse" whereby individuals cannot be held personally responsible for their depressed state of being (Drew *et al* 1999). This suggests that accountability is actively managed in talk about depression. However these studies did not examine how accountability was actively managed in depression discourse.

The depressed experience is constructed by lay individuals as non-pathological (Harvey, 2012). Depressed is often depicted as a state that an individual "can be", whereas depression is depicted as something that "enters" (Cassell, 1976; Fromm, 1979: 22; Harvey, 2012). The arrangement "I have depression" constructs possession and positions depression as an external object that the individual possesses. Whereas, the sequence "I am depressed" constructs depression as an enlargement of the self (Fleischman, 1999: 7). This suggests that subtle lexicogrammatical preferences impact on how identity is constructed and understood. Again, a discursive evaluation of the discourse would provide a more detailed examination of how identity is constructed and understood in depression discourse.

The intruding and possessive nature of depression is iterated through the use of a noun (*depression*) rather than a participial adjective (*depressed*). In the English language diseases are characterised as nouns rather than verbs. Positioning depression as a noun, constructs depression as a distinct entity rather than a normal reaction to an event or a normal human emotion (Warner, 1976). The term depression takes on an objectified ontological status that is separate from the individual's identity. This is similar to conceptualisations of other disease entities which are often comprehended as objects that intrude on the self (Cassell, 1976; McLeod, 1997; White, 1989). A consequence of objectifying depression is that it imparts depression as a fixed experience with little prospect of resolution (Harvey, 2012). Furthermore, objectifying depression promotes a mind-body dualism which marginalises the role of the individual in their illness experience (Harvey, 2012; Mintz, 1992; Warner, 1976). It also restricts a holistic view to illness excluding individuals, their personalities and social and environmental processes as factors in the development of their depression (Cassell, 1967; Warner, 1976). Consequently this situates individuals as passive in relation to their depression.

Harvey (2012) observed that when adolescents reported "having depression" to health professionals, they described their depressive experience through a medical perspective

and constructed their emotional distress as pathological and severe. Individuals with or without a formal diagnosis of depression embraced the technical concept of depression. The technical term "depression" appears to privilege the medical perspective as attention is drawn to depression's ontological status, for example, "this depression has got to me more" (Harvey, 2012). Individuals also have a readiness to adopt a diagnostic label of depression "I have severe clinical depression" "I have depression" (Harvey, 2012). In discourse that adopts the term "depression", depression was frequently described as an "*it" or* something that one has *"got"* ("it seems to be getting worse" and "I have got depression") (Harvey, 2012). This is similar to conceptualisations of diseases and disease symptoms which are often signified by the impersonal "it" and "the" (Cassell, 1967). This discourse again privileges the medical perspective. The use of medical discourse appears to be a rhetorical device used to protect the speaker's stake and interest, and present their accounts as factual. A discursive evaluation of depression discourse would enable a more detailed examination of such rhetorical devices.

Unlike the discourse associated with the sequence "I am depressed", the discourse surrounding the sequence "I have depression" lacks a set of triggers ("why do I feel like this"). This constructs depression as consuming and possessive. This leads to a description of the self as a passive and a powerless victim who has no influence over their depression (McLeod, 1997). In contrast to discourse surrounding the term "I am depressed", the term "I have depression" has been found to frequently be associated with self-destructive discourse; for example, "I have severe clinical depression I don't know what to do anymore, I took an overdose but my friend found out and told someone so now I'm alive. I wish she never found out I'd much rather be dead" (Harvey, 2012: 365). Asserting associations between depression and self-destructive impulses such as self-harm and suicide, emphasises the seriousness of the individual's distress. In doing so this pathologizes the individual's distress and distinguishes it from normal teenage emotional angst.

2.7. Summary

The qualitative research regarding depression has largely adopted narrative analysis and corpus linguistic techniques (Kuhnlein, 1999; Levitt, 2002). Qualitative research has highlighted how individuals construct depression by focusing on word usage. Two key constructs that were identified in non-discursive research are, "*I am depressed*" relating to negative life events or "*I have depression*" relating to pathology originating from the

individual (Harvey, 2012; Rude *et al* 2004). This research provides an insight into how depression is constructed. However, the use of narrative analysis and corpus linguistic techniques, mean that the analysis does not provide any details regarding what these constructions are used to accomplish or how they are attended to by others. The research has simply highlighted that these ways of talking about depression exist. This highlights the need for a thorough analysis of the construction of depression. The next chapter outlines discursive psychology which is a psychological approach that offers such an understanding.

Chapter Three – Discursive Psychology and Talk About Depression:

3.1 Overview:

Chapters one and two illustrated that the way depression is understood and talked about by individuals with depression and clinicians, varies. Therefore, chapters one and two illuminated the notion that the categories 'depressed and non-depressed', do not necessarily refer to real divisions; they are discursive constructs. This alludes to the notion that that what counts as depression is determined by discourse. This emphasises the importance of taking a discursive approach to examine how depression is constructed during therapeutic interactions.

The theoretical perspective adopted in the current research is discursive psychology (DP). A DP perspective was adopted because DP addresses the ways that activity involves or is constructed through discourse (Edwards and Potter, 2001). This is particularly pertinent with regards to therapeutic settings where therapy is constructed and achieved through discourse; hence the name 'talking therapy'. Adopting a discursive psychological perspective ensures that the discourse used in CBT sessions is central. It also ensures that the discourse is not viewed just as a resource but as a topic worthy of investigation. DP offers a fertile scheme for interpreting and making sense of, psychological talk (Edwards and Potter, 1992).

The current chapter will start by discussing social constructionism; the epistemological perspective underpinning DP. The chapter will then go on to discuss the key features of DP and how it can be utilised effectively in the current research project. The chapter concludes with a critique of the literature presented in chapters one and two from a discursive perspective.

3.2 Social Constructionism:

Traditional psychology often takes a realist approach, as it assumes that people can report experiences in an unproblematic way and treats language as a reflection of how things actually are (Forrester, 2010). Social constructionism challenges traditional psychology's perspective that researchers give voice to individuals (Braun and Clark, 2006).

The basic premise of social constructionism is that knowledge, the world we live in and our place within it, is collectively constructed (Gubrium and Holstein, 2008). Knowledge is socially produced. The world and the constructs within it, as well as sociocultural contexts are assumed to construct knowledge (Burr, 1995; Burr, 2003). Therefore, knowledge, identity and the phenomenon we experience cannot be posited as unproblematic fact or as given. Rather, it is socially derived and socially maintained. It is created by individuals who share meaning through being part of the same culture or society and is embedded within a network of social norms. Consequently, experience and knowledge is structured within or in opposition to cultural discourse (Kitzinger, 1994). Therefore, human activity is presented as an objectified reality; the world can be socially constructed by the social practices of people and at the same time experienced by them as if the nature of the world is pre-given and fixed (Berger and Luckmann, 1996; Burr, 2003; Wang, 2013).

Discourse is an important element within social constructionism. The world is understood through the social process of interaction. Discourse is viewed as an 'objective facility'. It provides all the text in which things can be externalised, objectified and internalised (Wang, 2013; Burr, 1995). For example, depression appears as an objective reality but is constructed through interaction between members of a discourse community.

3.2.1. Defining Features of Social Constructionism:

The emergence of social constructionism within psychology can be dated back to Gergen in 1973. Gergen (1973: 319) argued that 'all knowledge, including psychological knowledge, is historically and culturally specific'. Therefore, psychology should extend its enquiry beyond the individual into social, political and economic realms for a fuller understanding of psychological phenomenon and social life. Furthermore, as features of social life are continually changing, looking for definitive descriptions of people and society is futile (Burr, 1995: 11).

There is not an adequate definition or single description of social constructionism that would encompass all the different researchers who write within this paradigm (Burr, 1995). However, something that all social constructionism research has in common, is the view that discourse does not objectively reflect our world, identities and social

relations but instead it plays an active role in creating and changing them (Philips and Jorgensen, 2005). A more comprehensive definition of a social constructionist approach would be any approach that has one or more of the following key assumptions at its foundation.

Firstly, social constructionism takes a critical stance towards taken for-granted knowledge. It invites researchers to be critical of the idea that our observations of the world un-problematically yield its true nature to us (Burr, 1995). Therefore researchers need to be suspicious of taken-for-granted assumptions of the world (Gergen, 1985). Knowledge of the world is not based upon objective unbiased observations. It is influenced, constrained and shaped by social cultures and linguistic contexts (Burr, 1995).

This means that categories we perceive to apprehend the world do not necessarily refer to real divisions. Burr offers the following example; some music is classified as 'pop' and some as 'classical' (Burr, 1995). However, we should not assume that there is anything in the nature of the music itself that means it has to be divided up in that particular way (Burr, 1995). Therefore, from a social constructionist perspective, depression would be defined as a social construct not a scientific reality. For example, how people are defined as non-depressed or depressed is not due to real divisions. Rather, these categories are constructed by descriptions of depression that we find in specific cultures. This premise can help explain the differences between a diagnosis of depression in the IDC and DSM, discussed in chapter one. Furthermore, Greenberg (2010: 10) supports this premise by stating that "there was a time, and it was not very long ago, when people did not feel in their bones that they had depression, when Centres of Disease Control were not calling depression the common cold of mental illness, when the World Health Organisation was not claiming that depression was the leading cause of disability". This quote demonstrates how the construction of depression has changed over time and is likely to change again. Therefore, from a social constructionist perspective the interest is not whether the conceptualisations of depression are accurate. Social constructionism is interested in how individuals construct themselves, as either depressed or non-depressed, and how societies construct the categories depressed and non-depressed. It is also interested in how these categories/definitions of depression construct meaning and understanding.

Secondly, the categories and concepts we use and the way we understand the world, is historically and culturally specific (Burr, 1995). Therefore, any object can change over time and have different meanings in different cultures; "our knowledge of the world is the product of historically situated interchanges among people" (Gergen, 1985: 267). Chapter one demonstrated how depression has been conceptualised over time. For example, Greek conceptualisation of melancholy is very different to Freud's understanding of depression. Furthermore, depression has been understood differently in Western and Chinese cultures. A prominent conceptualisation of depression in Western society is that depression is a neurochemical deficiency in the human brain and taking antidepressants is an appropriate form of treatment. Whereas in Chinese society depression is conceptualised as resulting from exogenous causes, such as the loss of a loved one or breakdown of relationships (Wang, 2013). Therefore, all knowledge is culturally and historically relative. Again, social constructionism is not concerned with whether these different conceptualisations of depression are true or false. Social constructionism is interested in how these constructions of depression are culturally and historically specific.

Thirdly, social constructionism is interested in language and discourse of all kinds (Burr, 1995). Social constructionism postulates the idea that social processes sustain knowledge. Social constructionism views knowledge/understandings of the world, to be the product of social processes and interactions (Burr, 1995). Interactions between people are viewed as the practices in which shared versions of knowledge are constructed. Therefore, what people know about the world and themselves, is dependent on what they have been told (Raskin, 2002). For example, the cause of depression can be conceptualised as biological, psychosocial or as the result of unresolved conflicts. These conceptualisations are determined by interaction and exposure to discourse about depression.

Social constructionism also views discourse to be performative. Descriptions or constructions of the world sustain some patterns of social action and exclude others (Burr, 1995: 5). For example, conceptualising depression to have a biological cause would make people believe that taking antidepressants is the best way of curing it and perceive depression to be pathological. In contrast, viewing depression as a result of unresolved conflicts would lead people to view psychoanalysis as the most appropriate form of treatment. Consequently, language is viewed as productive rather than merely reflective (Burr, 2003; Edley, 2001). Discourse constructs reality in the same way as a

painting or drawing would. Therefore, reality is not necessarily mirrored in discourse; it is constructed by discourse (Edley, 2001).

3.2.2. Misconceptions of Social Constructionism Research:

Social constructionism is often misunderstood and criticised for denying the materiality of the body and denying that the world is made up of more solid matter than just words (Edley, 2001; Sampson, 1993). Statements from social constructionist researchers have stimulated these criticisms. Stating that 'there is nothing outside the text' (Derrida, 1976: 158), might be taken to suggest that from a social constructionist perspective the world is purely textual (Edley, 2001). The misconception is to assume that when a social constructionist states 'there is nothing outside of the text', they are making an ontological, rather than epistemological pronouncement (Edley, 2001). An ontological statement is a claim about what the world is actually like. To ontologically claim that reality is nothing without talk implies that you can somehow definitively know that to be the case. This is the precise assumption that social constructionism sets out to disturb (Edley, 2001).

For example, social constructionism does not deny the existence of depression but recognises that representations of depression are mediated by language and culture (Pilgram and Rogers, 1997). Therefore, the ontological status of depression, is not taken for granted but is treated as a medical discursive construct. Similarly, social constructionism is not denying the reality of feelings or the reality of neurotransmitter deficiency. Rather, what is being suggested is that when people are talking about depression, they are usually doing a lot more than simply reporting that they have a neurotransmitter deficiency or reporting upon how they feel inside.

Social constructionism is concerned with the constructive nature of descriptions, rather than the ontological entities that (according to the descriptions) exist beyond them (Edwards, 1997:48). Social constructionist researchers do not explicitly deny the existence of a world outside of talk. It maintains the presence of reality independent of our perceptions; and views discourse as a device that can bring into being a whole range of different phenomenon that are every bit as real as established ontological entities (Edley, 2001). Attempts to describe the nature of the world are subject to rules of discourse. Talk involves the creation or construction of particular accounts or stories of

what the world is like. Therefore, epistemologically speaking, reality cannot exist outside of discourse. Thus, social constructionism creates a theoretical foundation for discursive research (Edley, 2001).

3.3 Discursive Psychology (DP):

Discursive Psychology (DP) is the application of discourse analytic principles to psychological topics (Edwards and Potter, 2001). DP re-conceptualises traditional psychological topics and focuses on the occasioned, action-oriented and constructed nature of discourse (Edwards and Potter, 1992).

In traditional psychology there is an external, objective reality; which is conceived as the setting or the conditions that enclose the individual. Equally, cognition is conceived as something existing and quietly computing inside the individual (Edwards and Potter, 2001; 5). From a traditional psychology perspective discourse is viewed as an output and is treated as secondary to the cognitions they are supposedly representing (Edwards and Potter, 2001). DP inverts traditional psychology's perspective and views discourse as primary, and reality and cognition as secondary (Smith, 2008, Yardley, 1997). DP focuses on how individuals' versions of reality and psychological states such as depression are discursively constructed, attended to and understood during interaction (Edwards and Potter, 2001; Smith, 2008).

DP was created from the application of principles and methods from ethnomethodology, discourse analysis and conversation analysis (Hutchby and Woofit, 1998). One motive for inventing the term discursive psychology (Edwards and Potter, 1992) was to promote DA as something more than just a method (Fitch and Sanders, 2005). It can be distinguished from other analytical approaches to psychology, due to its treatment of individuals' discourse as a topic rather than a resource (Gilbert and Mulkay, 1984). DP perceives discourse to be central to everyday life. Nearly all activity involves or is constructed through discourse (Edwards and Potter, 2001). This is particularly pertinent with regards to therapeutic settings where therapy is constructed and achieved through discourse, hence the name talking therapy.

DP emphasises and tries to account for the detail, complexity and inter-changeability of discourse (Every and Augoustinos, 2010). DP is interested in what the depression

discourse accomplishes, rather than focusing on internal motives or feeling (Edwards and Potter, 1992). This concept is referred to in the discursive action model (Edwards and potter 1992, p154). DP focuses on what people do with their talk, rather than using discourse as a way of assessing what goes on in their minds (Wetherell, Taylor and Yates, 2001). There are three main concepts within the discursive action model: action, accountability and fact and interest. The focus in DP is on action not cognition. In the discursive action model psychological phenomenon, such as remembering and attribution, are recast as something that people do in their talk (Wetherell, Taylor and Yates, 2001). DP is interested in how remembering an illness experience is accomplished as a practical activity, what is it used for and what people are doing with their causal attributions of depression in everyday interactions. Therefore from a DP perspective, the question would become, how do people assign causes of depression in their descriptions and accounts? DP is also interested in how versions are assembled through discourse and presented as factual and independent of their producer (Edwards and Potter, 2001). Individuals treat others' accounts as motivated by self-interest. Therefore, versions of events can be discounted on the grounds of stake and interest. How individuals attend to these risks, in their accounts, is of interest to DP. This is referred to as the 'dilemma of stake and interest' (Edwards and Potter 1992, p 154). One of the ways stake and interest is managed in discourse is to construct accounts as factual. Authenticity is therefore seen as a discursive accomplishment. A variety of discursive devices help display accounts as factual, such as vivid description, narrative, consensus and corroboration (Wetherell, Taylor and Yates, 2001). Furthermore, DP is interested in how discourse attends to the issue of personal accountability, through the discursive action of blaming and exoneration (Wetherell, Taylor and Yates, 2001). Accountability is particularly important with regards to depression, as demonstrated in chapter two, depression discourse centres around the causes of depression and presenting the individual as a victim of biology or life-events.

Since talk and text are considered action oriented, versions are likely to show variability. This is because talk and text are indicative of the action or rhetorical orientation of the versions (Edwards and Potter, 1992). This variation provides another important lever for discourse analytic work, revealing the situated and functional character of versions (Edwards and Potter, 1992). Rather than trying to sort out a factual version from a false version, DP makes sense of this variability by considering the pragmatic contexts in which the two accounts occur. This approach may go some way to explaining the variation in conceptualisations of depression explicated in chapters one and two. From a

DP perspective the various constructions of depression over time reflect the situated and functional character of versions. A clear example of this is the emphasis on diagnosis and symptomology in the DSM-III after criticisms from the anti-psychiatry movement. In previous classification systems diagnosis played a marginal role. This is because it reflected the psychoanalytic perspective that symptoms did not reveal disease entities but disguised underlying conflicts that could not be expressed directly.

DP allows sensitive and complex discourse to be analysed. DP focuses on how depression is rhetorically presented, constructed and utilised in discourse. DP examines actual interaction in natural settings. The researcher does not stage the interactional discourse; it is the 'stuff of real life' (Potter, 2012). DP is the study of how interaction unfolds. It views discourse as inundated with psychological matters. DP has been particularly effective in tackling ideological questions that are not easily addressed by more mainstream social cognition perspectives (Augoustinos *et al* 2006). Furthermore, unlike other approaches, DP pays attention to the nature and organisation of institutional settings where individual's interactions invariably take place (Potter, 2012).

Discursive psychology offers an alternative analytic approach that re-specifies core psychological notions such as cognition, perception, embodiment and emotion and places the situated understandings of the participants at the core of the research (Potter, 2012; 41). DP's focus on peoples' practices makes it distinct from both mainstream experimental psychology and from a range of alternative qualitative methods (e.g. narrative analysis and interpretative phenomenological analysis which typically use open-ended interviews as their main technique of data generation) (Potter, 2012: 41). DP offers a more detailed and complex analysis of discourse. DP provides more than an overview of what is said; it provides a detailed analysis of what the talk accomplishes and how it accomplishes it.

3.3.1. The Application of Discursive Psychology to Applied Settings:

"Discursive psychology is a powerful tool for social change particularly when the matter at hand comprises of reoccurring interactional business" (Stokoe *et al* 2012: 2), this premise is particularly true for CBT sessions because the therapist deals recurrently with service users through talk, and embodies conduct in interaction. Discourse analysis can demonstrate how interaction works and how actions are accomplished. DP can go

further and reveal where interactional practices go wrong and how they might be put right. DP comes to the data open-mindedly and without agendas. DP's anatomy of talk is more detailed and has a sophisticated sense of the relationship between actions to be accomplished in CBT sessions and conversational structures that accomplish them (Stokoe *et al* 2012: 2).

The non-discursive literature presented in chapter two lacks the detail and sophistication DP provides. The research presented in chapter two highlights how lay individuals talk about depression but it does not examine the relationship between conversational structures and the actions being accomplished. It also neglects the interactional elements of dialogue. It reduces talk to frequencies and patterns rather than looking at talk as a topic. Because of this, non-discursive approaches are not equipped to analyse the sensitive and complex discourses occurring during therapeutic interactions. Therefore, a more detailed understanding of this talk is needed to understand what the talk accomplishes. For example, a discursive evaluation of this talk would examine and inform how depression is constructed and how accountability is actively managed in depression discourse. In addition to this chapter one reviewed how psychology and psychiatry conceptualise depression. It illustrated that the way depression is understood and talked about varies throughout history and within formal classification of depression. The differences between formal classification systems highlight how to date there is not one unifying classification of depression. It could therefore be postulated that what counts as depression is determined by discourse and is a discursive process. This emphasises the importance of taking a discursive approach to the literature, in order to determine how depression is conceptualised. All of the above demonstrates how DP is an appropriate approach for the current project.

To date DP has been applied to various settings. For example DP has been applied to neighbour dispute mediation to create a training workshop (Stokoe, 2011). It has also been applied to child protection help lines (NSPCC) to develop training aids and identify why problems might occur, and how child protection officers might counter these problems (Hepburn and Potter, 2003). Furthermore, DP has been successfully applied to men's talk about emotions and how emotion discourses function in the construction and negotiation of masculinity. The analysis generated possibilities for effecting change in men's emotional wellbeing (Walton, Coyle and Lyons, 2004; Walton, 2004). The above studies demonstrate how DP can be successfully utilised to analyse various facets of talk.

3.4 Summary:

Chapter three provided an overview of the theoretical underpinnings of the thesis and argues for the appropriateness of DP. In summary a DP perspective is adopted because it perceives action as involving or being constructed through discourse (Edwards and Potter, 2001). This notion is pertinent with regards to therapeutic settings where therapy is constructed and achieved through discourse. Adopting a DP perspective ensures that the discourse used in CBT sessions is seen as central and is viewed as a topic rather than resource. Furthermore, DP offers a fertile scheme for interpreting and making sense of psychological talk (Edwards and Potter, 1992). Non-discursive literature from chapters one and two has been critiqued on the basis that they lacked detail and sophistication. Non-discursive literature highlights how individuals talk about depression but does not examine the relationship between conversational structures and the actions being accomplished. This subsequently reduces talk to frequencies and patterns rather than looking at talk as a topic.

Chapter Four –Discursive Research on Depression:

4.1 Overview:

Chapter three demonstrated that DP can be successfully applied to dialogue in various settings and that non-discursive research lacked detail and sophistication. This is because non-discursive literature highlights how individuals talk about depression but does not examine the relationship between conversational structures and the actions being accomplished. The next section examines discursive literature regarding the construction of depression. It highlights the key discursive strategies lay individuals and professionals draw on to construct depression, and how depression has been constructed in public texts. This section aims to highlight how previous discursive literature has examined depression and highlights the gaps in discourse analytic research regarding depression.

4.2 How Public Texts Conceptualise Mental Health:

A prominent area of discourse analytic research regarding mental health is the analysis of public texts (Georgaca, 2012) because mass media is an influential mediator of information (Nairn, 2001). It is also an important source of information about mental health, which is absorbed and drawn on by the general public and professionals (Yankelovich, 1990; Gattuso, *et al* 2005; Seale, 2003a Bengs, 2008; Nairn, 2001). From a discursive perspective individuals with depression not only draw on discourse to construct different versions of reality but are also simultaneously the products of culturally specific discourses (Lafrance, 2007; Davies and Harré, 1990; Potter and Wetherell, 1987). This means 'individuals are both constrained and enabled by discourse' (Edley and Wetherell, 1997:206). Whilst a substantial amount has been written about mental illness and the media, little research is available on the specific representations of depression (Rowe *et al* 2003).

4.2.2 Discursive Constructions of Depression in Print Media:

Discursive research has shown that depictions of mental illness in print media are

predominantly negative (Narin *et al* 2001). Print media frequently links mental illness with violence, danger, failure and unpredictability (Allen, 1997; Coverdale, 2000; Coverdale, 2002). These constructions are written as common sense understandings and often written so that readers have to draw on such understandings to make sense of the account presented (Allen, 1997). Constructing individuals with mental illness in this way was utilised to convey individuals with mental illness as a risk, despite evidence that the percentage of crime committed by individuals with mental illness is no higher than that of the general population (Georgaca, 2012; Pilgrim and Rogers, 2003). This contributes to stigmatisation and negative public perceptions of the mental illness (Coverdale, 2000; 2002). It also encourages the alienation and avoidance of individuals with mental illness (Coverdale, 2000; 2002). Discourse analytic research of mental health legislation and mental health policy documentation, like print media, has shown how these are permeated by a discourse of dangerousness (Harper, 2004; Moon, 2000). Constructing mental illness as dangerous is used in legislation and policy documentation to legitimise the use of controversial and restrictive measures, on the grounds of safety and protecting the general public (Harper, 2004; Moon, 2000).

Another consistent finding of discourse analytic research of public texts is the use of biomedical discourse to construct depression (Blum and Stracuzzi, 2004; Gardner, 2003; Gattuso, 2005; Nikelly, 1995; Rowe, Tilbury, Rapley, and O'Ferrall, 2003). Depression was often constructed as a biomedical condition, specifically the consequence of faulty brain chemistry (Rowe *et al* 2003). Depression was also presented as an illness or disease and treatment often referenced symptom reduction via medication (Borman, 2003). This discourse works to normalise depression by presenting it as beyond the control of the afflicted individual (Rowe *et al* 2003). Furthermore, prominent consumer depression manuals glossed over contradictions in scientific research, in order to present depression as an illness with a singular cause; neurochemical imbalance (Gardner, 2003). Identifying depression as an illness and the use of biomedical discourse to construct depression in print media was used to help reduce stigma and challenge lay beliefs that depression is a personal inadequacy or weakness (McNair, Highet, Hickie, and Davenport, 2002; Gattuso, 2005).

Public texts often highlight the notion that women are more likely to be depressed and to receive medication for depression (Lafrance, 2007). Public texts described the onset of depression for men as sudden and dramatic whereas for women, onset was described as gradual, slow and suffocating (Johansson *et al* 2009). Causal factors of depression

were also a key focus of newspaper articles. The cause of depression for men tended to focus on external sources such as biology and stressful work. Whereas women were often blamed for their distress; focusing on the closeness of their relationships with children, partners, parents, and friends (Johansson *et al* 2009). Gendered discourses were used to protect men's masculinity and justify policing women's bodies with medication to enhance their productivity as workers and mothers in the 'new economy' (Lafrance, 2007; Gough, 2006). Mental health policy documentation emphasises this notion of self-management. It constructs "good citizens" as those who take responsibility for their depression and do not burden the health care system (Teghtsoonian, 2009). The concept of self-management is utilised to maintain the status quo and shift responsibility from the health care system to individuals (Blum and Stracuzzi, 2004; Gardner, 2003; Lafrance 2007; Rowe *et al* 2003).

Overall public texts have been described as portraying negative constructions of mental illness (Mayer and Barry 1992; Rowe *et al* 2003). This consequently aids stigmatisation and negative public perceptions of mental illness because the media is absorbed and drawn on by the general public (Yankelovich, 1990; Gattuso, *et al* 2005; Rowe *et al* 2003; Bengs, 2008; Nairn, 2001) and represents the most frequent encounter the public have with mental illnesses through news or media, where people with mental illnesses are often depicted as unpredictable, violent, and dangerous (Allen, 1997; Coverdale, 2000; Coverdale, 2002). Associating mental illness with violence enables discrimination because dangerousness and unpredictability are not socially tolerated (Arboleda-Flórez and Stuart, 2012). Furthermore, public texts often construct individuals with a diagnosis of depression (particularly women) as blameworthy and in control of their illness (Arboleda-Flórez and Stuart, 2012). Shifting responsibility onto the individual is another strategy utilised in public texts, which consequently aids stigmatisation.

4.3 Lay and Professional Discourses Regarding Depression:

The above section examined how depression is presented negatively in public texts and legislation. Public texts are an important source of information about mental health, which is absorbed and drawn on by the general public and professionals (Yankelovich, 1990; Gattuso, *et al* 2005; Seale, 2003a Bengs, 2008; Nairn, 2001). The following section examines discursive research that focuses on lay and professional constructions of depression, the self and others. It is divided into two sections. The first section looks at

how biomedical discourse is utilised to construct depression and the self within depression. The second section looks at how social discourses are utilised to construct depression and the self within depression.

4.3.1. Depression as Disease: The Prominence of Biomedical Discourse:

Biomedical discourse is one of the most dominant discourses of depression (Pitcher, 2013). The use of biomedical discourse is not restricted to the medical profession and mental health services, it also permeates the zeitgeist of contemporary culture (Georgaca, 2013). Furthermore, discourse analytic studies have shown that individuals with depression readily reproduce a medicalised version of their problems, even if they have never been in contact with mental health services (Georgaca, 2013; Lafrance, 2007; Lewis, 1995a).

4.3.2. How Depression is Constructed using Biomedical Discourse:

Within the biomedical discourse, depression is constructed as an organic medical problem with an identifiable aetiology (Schneider, 2010; Wilson and McLuckie, 2002; Young, 2009; Pitcher, 2013). Depression is also referred to as a disease that requires diagnosis and treatment from mental health professionals (Bennett, *et al* 2003). Discourse analytic studies have shown that within the medicalised discourse, depression is constructed as something that was inevitable and difficult to resist (Bennett, *et al* 2003). Depression is conceptualised as something that is solid, tangible and decontextualised, for example Bennett, *et al* (2003: 292) states that "depression is no longer used as a verb requiring an explanatory phrase: John is depressed because he has lost his job; Depression is used as a noun: John has depression". Biomedical discourse constructs depression as an independent entity (i.e. a biological condition), this locates depression within the individual/within the body and ignores external causal factors (Wilson and McLuckie, 2002; Lafrance, 2007; Georgaca, 2013; Pitcher, 2013). Within biomedical discourse 'personal flaws' and 'biological flaws' are presented as competing discourses, and the verification of the reality of one (a biological flaw verified through medical diagnosis), falsifies the other (personal flaw) (Lafrance, 2007). Thus, maintaining a medicalised account eclipses any consideration of how life events may have been 'depressing' (Lafrance, 2007).

Within biomedical repertoires, individuals also construct depression as a result of a hereditary biological deficiency, specifically neurotransmitter dysfunction (Johansson, 2009; Lafrance, 2007). To support the explanatory discourse individuals reference a family history of depression. The use of listing ('my mother, my brother, myself, my niece, my son') serves to further reinforce this claim, presenting depression as the unfortunate result of genetics. Furthermore, by comparing depression to 'hereditary' conditions such as diabetes and heart disease, an individual's experience of being depressed is presented as something inevitable that they were destined to have, regardless of life events (Lafrance, 2007). This gives depression legitimacy and enables individuals to disavow responsibility for their depression and defend against accusations that they are responsible for their own pain; as one cannot control one's own biochemistry or genes (Georgaca, 2013; Lafrance, 2007; Speed, 2006; Pitcher, 2013). However, locating depression within the individual can also result in individuals believing that there is something inherently wrong with them (Young, 2009; Pitcher, 2013).

Constructing depression as a biomedical disorder, located within the individual, also has implications for treatment as it suggests that the treatment for depression should target biochemistry rather than environmental or social factors (Pitcher, 2013). However, this construction is unhelpful in countries where poverty and violence are prevalent, as it disregards key risk factors for developing depression (Pretorius, 2012). Thus, biomedical discourse could be perceived as medicalising normal human emotion and disguising social inequalities (Pretorius, 2012; Pitcher, 2013).

4.3.3. Lay-Individuals Utilisation of Biomedical Discourse in Accounts of Depression:

4.3.3.1. *Prioritising the Voices of Mental Health Professionals:*

The biomedical discourse of depression prioritises the voices of mental health professionals (Lafrance, 2007). The discursive strategy of using 'reported speech' or 'active voicing', enables individuals' accounts of depression to be heard as the reported talk of another person (Hutchby and Wooffitt, 1998). The reported speech of a medical authority, positions the individual as passive and positions depression as the only possible understanding for their experience. This allows speakers to present this construction as the objective reality of depression (Pitcher, 2013; Lafrance, 2007). This position is defended further through the use of stake inoculation (Potter, 1996). This

positions individuals as free from blame because the statements are presented as factual rather than motivated by self-interest (Lafrance, 2007).

Prioritising the voices of mental health professionals constructs practitioners in a position of power and individual with depression as a patient or mentally ill person (Fee, 2000; Pitcher, 2013). This has repercussions regarding the individual's agency and credibility (Benson *et al* 2003). Accounts of experiences and events from individuals positioned as patients can be undermined as products of their 'disturbed mental condition' (Georgaca, 2013). Therefore, individuals often negotiated their self-construction as a patient, in order to regain credibility and legitimise their version of reality (Georgaca, 2000; Georgaca, 2004; Harper, 1995; Benson *et al* 2003). This was often achieved by drawing on discourses of normality and the denial of mental illness (Benson *et al* 2003). Prioritising the voices of mental health professionals was employed by lay-individuals to increase their rhetorical power (Crawford, 1999; Pitcher, 2013). Professionals have access to knowledge which is not readily accessible to patients, thus giving them rhetorical power (Pitcher, 2013). Prioritising the voices of mental health professionals, positions accounts from individuals with depression as expert and delegitimises other accounts (Crawford, 1999).

This power relation maintains the dominance of the biomedical perspective and highlights the relationship between power and knowledge (Parker, 2002). Foucault (1980) argued that knowledge and power are almost inseparable. Science exerts great rhetorical power as it is constructed as impartial, systematic and truthful (Lafrance, 2007). The prominence of biomedical discourse could be assumed to be a reflection of the incontrovertible nature of scientific findings and knowledge (Lafrance, 2007). However, there is an alternative perspective whereby biomedical discourse dominates, not because it offers objective truth, but because of its power to construct its particular version of reality (Foucault, 1966; 1973). Therefore, depression is considered a biological disorder, not through overwhelming evidence, but because of the economic, political and institutional power medicine has to shape individuals' views of the world (Lafrance, 2007).

4.3.3.2. Key Discursive Strategies Used by Individuals With Depression:

Discourse analytic studies have demonstrated that when individuals construct depression as a biomedical condition they draw on two key discursive strategies: constructing depression as a diagnosis, and comparing depression to physical conditions (Lafrance, 2007). Both these discursive strategies were used to validate experiences and legitimise identities.

4.3.3.2.1. 'It's Got a Name', Depression as Diagnosis:

Drawing on the notion of "diagnosis" in talk about depression is another example of the discursive strategy 'reported speech' or 'active voicing' and the prioritisation of the voices of mental health professionals (Hutchby and Wooffitt, 1998). Being given a diagnosis of depression was one of the most central ways in which individuals' experiences were medicalised. Individuals, who raised the issue of diagnosis in their discourse, constructed it as an experience that brought relief, validation and legitimisation (Lafrance, 2007). Individuals' accounts of receiving a diagnosis are situated as validating the reality of their depressive experiences (Lafrance, 2007). It is also used to the effect of validating their assertions that there was a problem that required medical treatment (Wisdom and Green, 2004; Issakainen, 2014). A diagnosis enables individuals to construct their distress as something 'serious' and 'real', as it has a recognisable aetiology ('they even have a name for it') (Lafrance, 2007).

Having 'a name' for their distress and using the pronoun 'it', objectifies depression and constructs it as an independent entity (Lafrance, 2007). Invoking a medical diagnosis to account for experiences of emotional distress, enables their pain to become 'realised' and constructs depression as having a reality of its own. Therefore, depression is isolated from the character of the sufferer and presented as a biological flaw. Diagnosis wards against having their experience constructed as their own subjective misinterpretation (Lafrance, 2007). Diagnosis is drawn on with the effect of defending speakers' experiences and personal identities (Lafrance, 2007). Discourse around diagnosis objectifies and isolates distress from the individual's character, as a medical diagnosis verifies that the individual has a biological flaw not a personal flaw (Lafrance, 2007). This position is further supported through reference to diagnostic criteria and the use of numbers as an objective measure of distress ('I was nine out of ten') (Lafrance, 2007). Discourse analytic studies have illustrated how blame and defence are

discursively interwoven. In individuals' accounts, diagnosis is used to defend against potential challenges that they have fabricated their pain to get attention or that they are to blame for depression (Lafrance, 2007).

4.3.3.2.2. " It's like Diabetes" Comparing Depression With Physical Illnesses:

Discourse analytic studies have demonstrated that when individuals construct depression as a biomedical condition they often compare depression to physical illnesses such as diabetes, cancer, heart disease, migraine, asthma, elevated cholesterol, impaired vision and broken bones (Schreiber and Hartrick, 2002). Comparisons drawn between depression and physical illnesses may not reflect the individuals' biomedical understanding of depression (Lafrance, 2007). One reason depression is compared to physical illness is because physical illnesses are situated under the purview of medical science, and afforded legitimacy (Burr and Chapman, 2004). Thus, having a physical illness is perceived as a legitimate excuse for inactivity or dysfunction (Lafrance, 2007). Individuals with physical illnesses or injuries are also often afforded empathy, encouragement, patience and tolerance more so than individuals with depression. Therefore, constructing depression as an "illness like any other" is an attempt to incur empathy and typical responses to physical distress (Issakainen, 2014).

Equating depression with 'diabetes', 'blond hair' or 'long legs' enables individuals to construct depression as one of many outcomes from the roll of the genetic dice. In this construction the individual is positioned as a blameless victim of genetic inheritance and depression is again constructed as an independent entity (Lafrance, 2007). The discursive strategy of comparing one's self to others is a well-established discursive strategy which enables individuals to construct their identity and warrant claims of authentic group membership (Widdicombe and Wooffitt, 1990; Wood and Rennie, 1994). Rogers *et al* (2001: 324) reported that people often felt "they had the wrong type of problem and that the right sort was essentially a physical one". Constructing depression as having physical symptoms allows depression to be preserved as a legitimate excuse for inactivity or dysfunction and consequently affording individuals empathy and tolerance (Issakainen, 2014).

4.3.3.3. How Biomedical Discourse is used to Overcome Stigma:

Notably absent in individuals' accounts, are comparisons between depression and other mental illnesses (Lafrance, 2007). This appears to be due to a hierarchy of stigma associated with depression, and other mental illnesses (Bennett, 2003). Discourse analytic studies have found that some illnesses are positioned as more socially acceptable than others. For example, the least stigmatised illnesses tend to be physical illnesses (with the exception of sexually transmitted infections) as they are often not associated with personal accountability (Bennett, 2003). Therefore, constructing depression as a medical condition may also be an attempt to defend against depression-related stigma (Issakainen, 2014). Furthermore, comparing depression to medical conditions may also have the effect of presenting depression as misunderstood and unduly stigmatised (Lafrance, 2007). Individuals often negotiate the legitimacy of depression by constructing themselves as 'worse off' because they are doubly victimised; once by their depression and again by a society that dismisses their pain (Lafrance, 2007). By constructing themselves as unfairly stigmatised and misunderstood, individuals are able to present themselves as even more worthy of sympathy (Lafrance, 2007). Therefore, social comparison can be used to demonstrate how one is both better off and worse off than other people (Widdicombe and Wooffitt, 1990). It also enables the negotiation of legitimacy for themselves and their contested experience of distress (Lafrance, 2007).

Biomedical discourse is often adopted to manage the stigma around depression. However, this also has implications for subjectivity (Schreiber and Hatrick, 2002). Constructing depression as the result of organic dysfunction frames depression as an independent entity (Luhrmann, 2000). This positions the individual as a blameless victim as one cannot control their genes or biochemistry (Speed, 2006; Pitcher, 2013). Women interviewed about their depression stated that they "felt relief when they were told their depression had a biological explanation as it meant that it was not their fault" (Pitcher, 2013: 20). Furthermore anti- stigma campaigns adopt a biomedical discourse in an attempt to remove attributions of responsibility from individuals with depression (Haslam, 2000). However, constructing depression as the result of organic dysfunction such as 'faulty neurotransmitters or genes' can position individuals as fundamentally flawed. By situating the cause of depression as a part of the individual's biological make-up depression is positioned as part of the individual and ultimately with them forever (Pitcher, 2013; Young, 2009).

4.3.3.4. The Limits of Biomedical Discourse for Legitimising Depression:

Discourse analytic studies have demonstrated that diagnosis and use of comparison have been effective discursive strategies for negotiating the legitimacy of individuals' experiences and protecting their identity (Issakainen, 2014). However, these discursive strategies only provide partial legitimacy (Issakainen, 2014). This is because the use of these strategies position depression as an experience that requires a defence and indicates an uneasy fit between depression and biomedical discourse (Wood and Kroger, 2000; Lafrance, 2007).

An important component for establishing legitimacy within medical discourse is the degree of tangible evidence demonstrating the 'reality' of their distress and dysfunction (Lafrance 2007). Depression is compared to physical illnesses because physical illnesses can be observed and understood, 'they can understand that, they can see it' (Lafrance, 2007). When the source of distress is directly observable, the individuals' character is not questioned and is permitted sympathy and understanding (Parsons, 1951). Individuals compare depression to a broken bone or heart attack stating that the afflicted has a 'wound to bear' (Lafrance, 2007). Without tangible evidence of the 'reality' of depression ('you don't have a broken leg, you look fine'), individuals' declarations of distress are positioned as illegitimate (Lafrance, 2007). The visible evidence of 'looking fine' overrides the subjective experience. Objective evidence such as blood tests or x-rays, are not available for depression. Therefore, biomedical discourse precariously legitimises individuals' experiences and identities (Lafrance, 2007). Moreover, the scientific neutrality of biomedicine ensures that it is the individual, not the biomedical model, which is blamed, when the subjective experience of the individual does not fit within the boundaries of medical legitimacy (Kirmayer, 1988; May, Doyle, and Chew-Graham, 1999; Lafrance, 2007). This intensifies suffering and with the pervasive threat of illegitimacy individuals must negotiate the assumptions of biomedicine when accounting for their everyday experiences of depression (Kleinman, 1995; Lafrance, 2007).

4.3.4. Professionals' Utilisation of Biomedical Discourse in Their Accounts of Depression:

Mental health professionals tend to draw upon medical discourse to construct depression (Thomas-MacLean and Stoppard, 2004). In contrast to service users

accounts of depression in discourse analytic studies, which focus on the way individuals draw on available discourse to construct their accounts and experiences of depression. Discourse analytic studies of professionals' accounts are focused on the discursive strategies professionals use to justify their actions (Georgaca, 2012). Discourse analytic studies focusing on professional discourse have demonstrated that professional practice is not based on the objective implementation of scientific procedures but are constructions influenced by institutional, social and practical considerations.

4.3.4.1. Professional Descriptions of Depression:

When discussing the aetiology of depression, depression was positioned as physiological in nature and the result of a biochemical imbalance (Thomas-MacLean and Stoppard, 2004). This depiction of depression enables professionals to justify recommending pharmaceutical treatment options. This is not an unexpected construction as the DSM-5 and ICD-10 both recommend pharmaceutical treatment for depression (American Psychiatric Association, 2013; WHO, 2010). Discourse analytic studies have demonstrated that when professionals construct depression as a biomedical condition they, like service users, often compare depression to physical illnesses such as diabetes (Thomas-MacLean and Stoppard, 2004). For example, a physician stated that she tells her patients that depression is 'no different' from diabetes', an analogy that was often used by other mental health professionals (Thomas-MacLean and Stoppard, 2004). Again this may not reflect the objective nature of depression, but rather help professionals construct their approach to depression as routine and no different from their approach to other physiological conditions.

When depression could not be attributed to life events, mental health professionals characterised it as 'true depression', that is, purely biological in origin. (Thomas-MacLean and Stoppard, 2004). Truthfulness has great rhetorical power and this statement contributes to the power hierarchy between physical illnesses and mental illnesses. This statement has implications for the legitimacy of depression and could explain the prominent use of biomedical discourse when individuals with depression negotiate the legitimacy of their distress.

4.3.4.2. Constructing Subject Positions:

Professionals actively manage responsibility and blame and employ discursive strategies to justify the continuation of practices despite their sometimes problematic character. These discursive strategies include depicting individuals with a diagnosis of depression as severely ill and constructing depression as something that is 'wrong' with patients (Thomas-MacLean and Stoppard, 2004). Stressing the severity of depression and assuming the existence of a biologically based condition enables professionals to justify the continuation of treatment that may be controversial or have adverse effects. Electroconvulsive therapy (ECT) recipients were constructed as passive, compliant and a little anxious when expressing neutral or positive views about ECT. However, when criticising ECT, recipients were constructed as unreliable, unreasonable, irrational and mentally ill (Johnstone and Frith, 2005). This highlights the flexibility in which professionals implement discourses to justify their actions.

Professionals are correspondingly positioned as experts and their influence as professional judgment (McMullen, 2012). Medical authority is used to provide legitimacy and self-evident character; in which mental health professionals adopt an impartial position weighing the risks against the benefits. Rhetoric around diagnosing depression enables mental health professionals to position themselves as knowledgeable, proficient and caring. When discussing how patients responded to receiving a diagnosis of depression, one mental health professional stated 'generally people take it . . . They know something is wrong' whilst another stated 'they are glad that you made the diagnosis, that finally somebody's found out what's wrong with me' (Thomas-MacLean and Stoppard, 2004).

4.3.4.3. Treatment Negotiations:

As previously demonstrated, discourse analytic studies of professionals' accounts are focused on the discursive strategies professionals use to justify their actions (Georgaca, 2012). Using biomedical discourse allows professionals to justify their actions and construct self-evident character (Georgaca, 2012). Professionals actively manage responsibility and blame, and employ several discursive strategies in order to justify the continuation of treatments despite their adverse side effects and failure (Georgaca, 2012). Self-control was a discursive strategy employed by professionals to shift

responsibility away from the medical institution and on to individuals (Willig, 2000). Professionals conveyed the idea that depression is a condition for which patients must accept some responsibility (Thomas-MacLean and Stoppard, 2004). Health promotion discourse constructs people as permanently 'at risk' and therefore personally responsible for their physical and mental wellbeing (Lupton, 1995; Kugelmann, 1997). Another notion is the concept of joint decision making which positions individuals as in charge of and responsible for maintaining and helping themselves (Brown, 1999).

The construction of depression as a biomedical disorder, locates the cause of depression within the individual (Young, 2009). This has implications for treatment as it suggests that the treatment for depression should target biochemistry rather than environmental or social factors (Pitcher, 2013). Discursive formulations of medication use are a prominent focus of discursive research and position anti-depressant medication as a way of restoring normality and control. Discursive formulations of medication use also position individuals as neurochemically deficient rather than morally failing (Fullagar, 2009).

The use of medication is often critiqued for its adverse effects. Therefore individuals and mental health professionals utilise various discursive strategies to justify the use of medication. A common discursive strategy used by professionals and individuals to justify taking medication, was to liken depression to physical illnesses or to taking antibiotics for an infection (Oliphant, 2009). Another common discursive strategy used by professionals and individuals is to conceptualise depression as a chemical imbalance, and therefore position antidepressants as a necessary treatment of depression. Furthermore individuals and professionals characterised depression as 'true depression' when it is purely biological in origin and could not be attributed to life events (Thomas-MacLean and Stoppard, 2004). This delegitimises depression and implies that individuals who do not use antidepressants do not suffer from 'true' depression (Oliphant, 2009).

When advocating the use of antidepressants to treat depression, professionals and service users also employ discursive strategies to negotiating the efficacy of adverse side effects (Liebert and Gavey, 2009). There are three key discursive strategies: minimising the significance of risks, risks with benefits and questioning the validity of risks (Liebert and Gavey, 2009; Stevens and Harper, 2007). These discursive strategies rhetorically contain and undermine evidence of serious adverse effects from

antidepressants such as akathisia (a movement disorder), aggression and suicidality (Liebert and Gavey, 2009; Stevens and Harper, 2007). When discussing the implementation of controversial and socially contested treatments such as ECT, professionals actively manage the concerns through similar discursive strategies (Stevens and Harper, 2007). However, they also construct ECT recipients as severely ill to support choosing who should receive ECT and warranting the use of urgent physical treatments. Professionals also discount the therapeutic value of alternative, non-physical interventions (Stevens and Harper, 2007).

When professionals and individuals justify the use or non-use of a treatment, they actively protect their stake and interest and draw on various information sources to support their decision-making. 'Empirical knowledge' was a common discursive strategy, used by patients and clinicians to justify the use or non-use of a treatment (Oliphant, 2009). Using words such as 'evidence' 'speak to your Dr' and 'Google', allowed the individual to frame their account as factual because they have used expert and experimental knowledge to support their claim (Oliphant, 2009). Personal experience and common sense notions were also used as to justify the use or non-use of a treatment (Oliphant, 2009). Discourse analytic research has found that there is a hierarchy of information sources. Personal experience was viewed as the most authoritative information source, followed by scientific research and lastly hearsay information, gained from friends or family (Oliphant, 2009). However, scientific research surpassed personal experience when using the Food and Drug Administration (FDA) as an information source because this was viewed as the gold standard for scientific evidence and testing (Oliphant, 2009).

4.3.4.4. Implications of Utilising Biomedical Discourse:

4.3.4.4.1. Scientific Discourse Promotes Cohesion Between Professionals:

The use of biomedical discourse allows practitioners and academics within organisations to 'speak the same language' (Zeeman and Simons, 2011). Those who utilise biomedical discourse participate in conversations and are included in prominent practices. Those who do not utilise technical biomedical language are excluded from conversations because of their inability to participate in the conversations (Zeeman and Simons, 2011). The biomedical discourse strengthens professional positions and binds professionals together as they belong to the same body of knowledge (Foucault, 1979;

1984a; Parker 1998). It also marginalises those who are unfamiliar with the technical language. This highlights the link between power, knowledge and language (Zeeman and Simons, 2011).

4.3.4.4.2. Stigmatisation by Mental Health Professionals:

The interaction between mental health professionals and service users in clinical settings has scarcely been researched discursively. The few studies that have examined interactional practices have interviewed patients and practitioners retrospectively. Practitioners emphasised the importance of establishing rapport with their patients and of possessing knowledge about the social context of their lives (Thomas-MacLean and Stoppard, 2004). Whilst biomedical discourse creates cohesion between professionals, it does not establish rapport. Individuals exposed to mental health services often describe mental health professionals as stigmatising (Arboleda-Flórez, and Stuart, 2012), stating that professionals made them feel punished, patronised and humiliated. Other problems included not being given sufficient information about depression and their treatment options (Arboleda-Flórez, and Stuart, 2012).

Overall mental health professionals tend to draw upon biomedical discourse as a routine matter of practice. They utilise biomedical discourse to justify their actions and construct themselves as knowledgeable, impartial and caring. The use of biomedical discourse is not simply the implementation of scientific evidence, but rather constructions influenced by institutional, social and practical considerations (Georgaca, 2012).

4.4 "Wherever There is Power There is also Resistance" - The Utilisation of Social and Psychological Discourses of Depression:

As established above, biomedical discourse has great rhetorical power and is frequently utilised in discourse about depression. However, "wherever there is power there is also resistance" (Foucault, 1980: 142). Resistance to biomedical discourse is evident in discursive research through the utilisation of social and psychological discourse (Pitcher, 2013). Secondly, resistance to biomedical discourse is also displayed through comments regarding accomplishments and social integration, as dominant discourses often portray depression as isolating, shameful and a personal weakness (Young, 2009).

Individuals referenced their lived experiences and how it differed from hegemonic constructions of mental illness (Young, 2009). The following section will focus on biomedical resistance discourse, such as uses of social and psychological constructions of depression and recovery discourse.

4.4.1. How Service Users and Professionals Draw on Social and Psychological Discourse in Their Accounts of Depression:

Discourse analytic research often focuses on how individuals draw upon discourses to make sense of their experiences and construct explanatory frameworks for depression. Individuals rarely liken depression to any single casual factor. Instead, individuals' discourse incorporates a complex web of interacting circumstances (Johansson *et al* 2009). For example, a family history of depression, variations in hormone levels, faulty neurotransmitters and high demands at work or home (Johansson *et al* 2009). However, when individuals with depression constructed explanatory frameworks for their experiences, they often conceptualised depression as the result of social circumstances, often referred to as stressors; particular life events that reduce happiness (Bennet *et al* 2003; Lewis, 1995; Link *et al* 1999; Jorm, 2000; Crowe, 2005).

Mental health professionals also emphasise the importance of understanding individuals' social and cultural experiences. Possessing knowledge about the social context of service users' lives helps to provide facilitative and meaningful care (Crowe, 2002). It also helps establish rapport and enhances the psychotherapeutic relationship (Crowe 2002; Thomas-MacLean, and Stoppard, 2004). Mental health professionals construct depression in marginalised groups as highly heterogeneous and inextricably linked to social relationships, social disadvantage and marginalisation (Körner *et al* 2011). Furthermore, mental health professionals in social care settings often framed their work in terms of addressing challenges confronted by all people moving through particular phases of life. They highlighted multiple aspects of life that could affect health and wellbeing and avoided biomedical discourse (Mitchell, 2009).

The conceptualisation of depression, as the result of social circumstance and the avoidance of biomedical discourse, is used to normalise experiences of depression and avoid pathologizing distress (Mitchell, 2009). Furthermore, acknowledging the social and cultural context of depression shifts the focus away from the individual with

depression. This reduces responsibility as it implies that the cause of depression does not lie solely with the individual (Crowe, 2002). The choice of discourse utilised to explain experiences of depression may alter individuals' help seeking behaviour and their response to treatment (Razali *et al* 1996; Jorm, 2000).

4.4.2. The Construction of Depression as a Gendered Disorder:

Men and women construct depression differently. Men tend to focus on external sources such as a stressful work environment whereas women often blame themselves, disparaging themselves as incompetent and fatigued (Johansson *et al* 2009). Women also tended to draw on the traditional female gender role "the good woman" and not meeting gender role requirements was often referred to as a contributor to women's depression (Lafrance and Stoppard, 2006).

Furthermore, as previously demonstrated, depression is often constructed as a gendered disorder and consequently diagnosed in women more than men (Johnson *et al* 2012). This could be because diagnostic criteria often perpetrate and reproduce gender stereotypes (Johnson *et al* 2012). This increases stigma associated with depression, as depression is often viewed as a female disorder (Johnson *et al* 2012). To reduce stigma associated with depression men construct and defend their masculinity (Emslie *et al* 2006). This discursive strategy incorporates values associated with hegemonic masculinity into discourse, for example "being one of the boys". This strategy was used to aid recovery and emphasise ''normality''. However, the conflict between the pressures to conform to the standards of hegemonic masculinity and the perception that depression is a "female disorder" could contribute to increased suicidal behaviour in males with depression (Emslie *et al* 2006).

Recovery discourse is the most critical of biomedical constructions of depression and is also entwined with gendered discourse (Speed, 2006). It emphasises the importance of becoming stronger, letting go, saying no to others and relinquishing practices associated with the demands of women's "good woman" selves such as caring, cooking and cleaning (Lafrance and Stoppard, 2006). However, becoming stronger is in conflict with femininity. Therefore, women actively draw on discourse that defends their femininity. This discourse incorporates values associated with hegemonic femininity for example being "gentle, kind and caring" (Lafrance and Stoppard, 2006).

4.4.3. Depression is a Personal Failure –Negotiating Accountability for Depression:

Individuals with depression who have attempted suicide draw on moral discourse, constructing depression and suicidal acts as a personal failure; indicative of deviance, insanity and overall questionable integrity (Bennet *et al* 2003). Furthermore, the suppression of negative feelings is viewed as a moral attribute. For example, in contemporary British society to say that someone 'wears their heart on their sleeve' is usually meant pejoratively. Therefore, help seeking occurs when the desire for alleviation outweighs the value of suppression (Williams and Healy, 2001).

Although biomedical and social discourses construct depression in different ways, they also share similarities. Both construct depression as an abnormality (Wilson and McLuckie, 2002; Pitcher, 2013). This isolates the individual with depression outside the range of "normal" human experience and can lead to individuals feeling like a failure and responsible for their depression (Wilson and McLuckie, 2002; Pitcher, 2013).

Discourse analytic research has found that individuals actively resist taking blame for their depression and construct themselves as "worthy persons". This is a discrepancy compared to traditional depression research, in which individuals with a diagnosis of depression are described as inherently self-blaming (Drew *et al* 1999). Responsibility for public health has shifted away from the state and its institutions and on to individual citizens (Willig, 2000). Health promotion discourse constructs individuals as permanently 'at risk' and simultaneously in charge of their mental and physical wellbeing (Lupton, 1995).

A discursive strategy used to resist taking responsibility for depression is the construction of two separate identities: the depressed and non-depressed self (Lafrance and Stoppard, 2006). Constructing an alternative identity reduces the responsibility for depression, as it was the flawed ''depressed person'' who was deviant and "insane". Rather than their ''authentic self'' that is, the person who they are when they are feeling good and happy (Bennet *et al* 2003). This discourse is consistent with previous research that suggests a lost sense of identity is a characteristic of depression (Stoppard, 2000). Furthermore, constructing an alternative identity was also used to emphasise ''normality'' and position themselves as "happy" and someone not to be avoided. Being perceived as ''normal'' was constructed as the antithesis of depressed, and an effective

barrier to future difficulties and maintaining positive mental health (Bennet *et al* 2003). Constructing two separate identities, the depressed and non-depressed self, is also utilised in recovery discourse. After recovery, individuals constructed themselves as fundamentally different from the person they had been before they became depressed (Lafrance and Stoppard, 2006). Individuals depicted their former "depressed" identity as unsuitable, and they constructed their recovered self as disengaged from their former "depressed" self (Lafrance and Stoppard, 2006). This again helps position individuals who have recovered from depression as "normal" and their experiences within the range of "normal" human experience, rather than a flawed individual who was destined to be depressed (Wilson and McLuckie, 2002; Pitcher, 2013).

4.5 Summary:

Chapter four has explored how print media, lay individuals and professionals construct depression. It found print media often associated mental illness with violence, dangerousness and unpredictability which promoted stigmatisation (Arboleda-Flórez and Stuart, 2012). Additionally public texts often constructed individuals with a diagnosis of depression (particularly women) as blameworthy and in control of their illness, and portrayed depression as the result of a biological deficiency (Arboleda-Flórez and Stuart, 2012). The use of biomedical discourse to construct depression was a prominent finding of discourse analytic research. Mental health professionals tend to draw upon biomedical discourse to justify their actions and construct them self as knowledgeable, impartial and caring. This is in contrast to service users who drew on biomedical discourse to construct and legitimise their accounts and experiences of depression. Depression was also constructed as intrinsically immersed in the social context of individuals' lives. Other studies found depression was constructed as a gendered disorder and a personal weakness. Examinations of recovery discourse highlighted how individuals constructed their depressed and non-depressed identity, to manage accountability for depression and construct normality.

To date mental health professionals' and service users' constructions of depression have been examined separately and retrospectively via interview. They have focused on explanatory frameworks, treatment choices and diagnosis. No research has looked at how depression is jointly constructed and attended to during therapeutic interaction. Furthermore, previous discursive studies highlight how individuals who have

previously had an episode of depression construct identity but do not examine how identity is constructed by individuals currently seeking help for depression. None of the studies examined how individuals constructed identity during therapeutic interactions.

Chapter 5 - Discursive Approaches to the Analysis of Psychotherapy

5.1 Overview:

Chapter four demonstrated how a discursive methodology could be effectively utilised to examine constructions of depression. It highlighted that there was a limited amount of discursive literature focusing on how individuals and mental health professionals construct depression and the research that did, examined these separately. Chapter five aims to demonstrate how a discursive methodology can be applied to therapeutic interactions. To date no discursive analyses have been conducted regarding the construction of depression in UK therapeutic settings. In addition to this a limited number of studies have employed discursive methodology to examine psychotherapy and even fewer analyse therapy transcripts (Avdi and Georgaca, 2007). The following section reviews the limited number of studies that employed a discursive methodology to analyse transcripts of psychotherapy sessions and gives a brief overview of conversation analytic studies of therapy sessions.

5.2 Conversation Analysis and Psychotherapy:

Conversation Analysis (CA) is distinct from DA. CA focuses on the design of language at a technical level, focusing on the communicative competencies that inform therapeutic conversation. DA enables an interpretive understanding of the functions these technical competencies accomplish in therapeutic interactions. There are nevertheless similarities and overlap. For example they both offer qualitative analysis of the functional and sense-making properties of language (Wooffitt, 2005). CA and DA both treat language as a topic and focus explicitly on language as social action, and are attentive to the properties of how language is actually used (Wooffitt, 2005). Therefore the CA work on therapeutic interactions will be reviewed below.

CA has a long history of examining therapeutic interactions. This history began with Sacks' (1992) description of an emergency psychiatric helpline and an adolescent group therapy session, and Turner's (1972) CA examination of how therapy is conducted. However, the landmark paper by Davis (1986) on therapists' reformulations of clients' talk, encouraged a burgeoning of CA work. It found that the process of converting a service user's everyday troubles into a form amenable to therapy occurred by using formulations which were used to select a particular issue from the client's conversation, and construct this as the problem to be worked on. Since then CA research has been

used to examine: psychiatric consultations (e.g. Bergmann, 1992); GP Consultations (e.g. Beach, and Le Baron, 2002); counselling (e.g. Silverman, 1997), psychoanalytic consultations (e.g. Vehvila¨inen, 2003), psycho-dynamic-interpersonal psychotherapy (Madill *et al* 2001) support-oriented help lines (e.g. Pudlinski, 2005), cognitive behaviour therapy (e.g. Antaki *et al* 2004, 2005) and child counselling (Hutchby, 2005). All of these studies have explicated the practices of therapy by demonstrating how the therapist conducts therapeutic work.

CA postulates that psychotherapy achieves its aims through exchange of talk and is therefore interested in what the therapist has to do (e.g. to hear the client out, and be seen to have done so, and move the consultation forward) and how sessions are actually conducted. Through this endeavour CA research has postulated various linguistic tools, utilised by therapist to accomplish therapeutic goals. These include, but are not limited to: troublesome formulations (Drew, 2003); disclosures of personal information (Farber, 2003); lexical choice and prosody (Perakyla *et al* 2008); narration of personal experience (Ferrara 1994), dream narration (Ferrara, 1994), repetition of others' talk (Ferrara, 1994), construction of metaphors (Ferrara, 1994), the joint production of utterances (Ferrara, 1994); turn taking (Perakyla *et al* 2008); lexical substitution (Vehviläinen 2008); reinterpretative statements (Peräkylä, 2004); questioning (Peräkylä, 1995); extended agreement (Vehviläinen, 2008) and elaboration (Vehviläinen, 2008). Two key concepts from CA research in psychotherapy are problem formulations and reinterpretations. Problem formulations are utterances in which the current speaker provides meaning to what another speaker has said (Garfinkel & Sacks, 1970). A formulation is selective as it foregrounds something in the prior talk, and leaves something in the background (Antaki, 2008). Reinterpretations, are utterances that invite the service user to orient to new understandings proposed by the therapist. Although reinterpretations are grounded in what the service user has said, they are expressed from the therapist's own perspective and are therefore possibly different from what the service user meant (Rossano and Viaro, 2008). Reinterpretations are often signalled by the use of perspective markers, such as I think.

Although a larger amount of CA research has focused on psychotherapy interaction and clinical consultations, a limited amount of CA research has focused on interaction during CBT sessions. Antaki addressed how the 'negotiation' of problem identification can be problematic in CBT. Problem identification in therapy has been postulated by CA

research to be a product of interaction between client and therapist in which the meaning and significance of the client's experiences are negotiated (Madill, Widdicombe, Barkham, 2001, p. 415). Ankaki (2004) demonstrated that there might be a mismatch between the service user and therapist's understandings of how a 'problem' should be handled. The therapist avoided troubled responses to formulation by moulding the service user's problem into a general, universal template. This was discursively achieved by a genre of school-room didactic question- and-answer exchange. Another study attempted to investigate how the CBT model is implemented in therapeutic interaction. It focused on the conversion of the service user's problem into CBT terminology and articulation as the problem statement. The problem statement is an integral part of CBT. This was achieved by the therapist's ability to guide the service user's acceptance of the model of therapy, culminating in the latter's agreement with the problem statement. This expertise is evident in the therapist's use of formulation to aid in guiding the service user's account. The therapists also utilised technical questions, reported speech, and hedging devices (Beckwith, and Crichton, 2010). Furthermore Simmons (2010), examined the ways in which therapists attempt to initiate behavioural change in service users during CBT sessions. The analysis showed that when therapists approached the practice of behavioural activation by proposing their own suggestions for behavioural change, resistance occurred. In contrast, when therapists approached behavioural activation via questioning and the use of collaborative dialogue, such as gist formulations and collaborative completions, troubled responses did not occur.

Overall this brief summary demonstrates the significant contribution CA has made to the study of therapeutic interactions and the therapeutic process. However, this research focuses on the design of language at a technical level, focusing on the communicative competencies that inform therapeutic conversation. A discursive examination of therapeutic interactions would enable an interpretive understanding of the functions these technical competencies accomplish in therapeutic interactions. Therefore CA would not enable an understanding of what the therapeutic dialogue accomplishes and what it is being used to do in interaction. Furthermore, a discursive approach can also enable an understanding of how psychological phenomena such as depression are constituted and negotiated. Paradoxically, this is in contrast to some CA research which takes a traditional position on the relationship between cognitive phenomena and socially organised interactional practices. Overall DA can examine the relationship between conversational structures and the actions being accomplished. CA is more concerned with the fine grained and detailed analysis of conversational

structures.

5.3 Discursive Research and Psychotherapy:

5.3.1. Overview:

The growing trend to utilise a discursive methodology to analyse psychotherapy has produced a fruitful insight into: *The Attribution of Blame; Identity; Subjectivity; Wider Discourses in Therapy; The Role of The Therapist* and *The Therapeutic Relationship.* These processes and their contribution to the literature will be reviewed in turn below. Although the reviewed literature provides an insight into how psychotherapy can be examined through a discursive methodology, it has some key methodological flaws that are discussed at the end of the chapter.

5.3.2. The Attribution of Blame:

Discourse analytic studies of therapeutic interactions suggest a central issue in therapeutic dialogue concerns the negotiations of responsibility and blame of the service users' difficulties. Edwards (1995), in a discursive analysis of couples' counselling sessions, identified a number of discursive devices used to manage accountability in therapy; for example the use of modal verbs ("she would...") and the use of if-then structures. Edwards postulated that partners utilised these discursive devices to construct "script formulations", that is descriptions that construct events as routine or exceptional. Positioning events as exceptional enabled partners to resist and manage accountability in relation to troubled talk.

The majority of literature focuses on the attribution of responsibility and blame in systemic therapy (e.g. Kurri and Wahlstro¨m, 2005; O'Reilly, 2014; O'Reilly, 2005; O'Reilly, 2007; Stratton, 2003). This could be because systemic therapy has a constructionist and interactional focus (Avdi and Georgaca, 2007). Within the context of systemic therapy it was found that the performative nature of family interactions, centred on parental accountability (Stratton, 2003). Parents attributed blame to the child and made direct appeals to the truthfulness of their accounts (O'Reilly, 2014). Similarly, O'Reilly (2007) found that family members seeking systemic therapy for a child with conduct issues utilised the concept "naughty child" to manage accountability.

In couple systemic therapy sessions, accountability was found to be situated around two discourses regarding moral justification: autonomy and relationality (Kurri and Wahlström, 2005). Moreover, Stancombe and White (1997) and (2005) suggest that when families attend therapy, individual members often depict competing accounts regarding the family's difficulties and who is to blame for them. During systemic therapy, with a family facing parental separation, the female partner utilised a 'managing change' discourse. This positions separation as a problem that requires therapy, and implicitly blames the husband for the problem. However, the male partner utilised an 'evolutionary change' discourse, which constructs the separation as a natural process that can be resolved by the family in time and thus exonerates him from blame. These studies demonstrate how a discursive methodology can be applied to therapy transcripts, to examine how blame attributed and defended during therapeutic interactions.

5.3.3. Subjectivity:

The largest group of discursive studies in therapeutic interactions focus on subjectivity. In discursive research, subjectivity is reformulated as a discursive accomplishment, jointly constructed in therapeutic interactions. The following section looks at subjectivity regarding the self, subject positioning and the utilisation of wider discourses in therapeutic interaction.

5.3.3.1. The Self-Analytic or Self-Reflective Function:

One aspect of subjectivity that has been explored in several studies is the self-analytic or self-reflective function, i.e. the service user's capacity to observe, reflect and analyse their experience and behaviour. This is a central focus of discursive examination of psychoanalytic therapy because distinguishing between the experiencing and observing ego is postulated to enable the service user to internalise the function of the therapist, become self observing and thus enable change (Avidi and Georgaca, 2007).

Nye (1994) looked at the development of the service users' self-analytic function based on a linguistic discourse analysis of ten psychoanalytic psychotherapy sessions. The self-analytic function was examined in relation to the utilisation of referential and evaluative clauses (i.e. sentences which denote facts and sentences which denote meaning). In short, the analysis demonstrated how the service user becomes more active in trying to

establish the meaning of their narratives, whereas the therapist becomes correspondingly less active. Similarly Wodak (1996) employed critical discourse analysis to examine self-reflection in group therapy. The analysis demonstrated how in the latter stages of therapy, service users displayed more self-contemplation and realistic assessment of their experiences. These studies present self-reflection as a linguistic marker for change. They ignore the psychotherapeutic premise that self-reflection is an internalised, psychological capacity acquired gradually through the process of therapy. Therefore the assumption that discourse analysis can examine or comment on inner-self orientation or an individual's psychological wellbeing, sits uneasily with the theoretical underpinnings and aims of discursive psychology. Furthermore they focus almost exclusively on the service users' dialogue and downplay the interactional aspect of self-reflection, and what self-reflection accomplishes during therapeutic interactions.

5.3.3.2. Subject Positioning:

Another way in which subjectivity has been examined discursively during psychotherapy is through the notion of subject positioning. Subject positions are achieved by individuals negotiating different identities and accounts which reflect the contingencies of the situation and wider discourses available (Wetherell, 1999). Various subject positions are actualised from moment-to-moment, and these may be offered, accepted, claimed or resisted by the individual (Davies and Harré, 1999). Thus, the use of discourse creates subject positions but these are also contingent on the individual's understanding of the discourse (Avdi and Georgaca, 2009). The discourse analytic research regarding the notion of subject positioning in psychotherapy has looked at three main themes: breadth and the flexibility; agency; and the role of wider discourses.

A number of discourse analytic studies focus on the flexibility with which service users employ a diverse range of subject positions during psychotherapy (Avdi, 2005; Burck *et al* 1996; Diorinou and Tseliou, 2014; Fosh *et al* 1996; Karatza and Avdi, 2011; Madill and Barkham, 1997). A discursive analysis of eight psychodynamic-interpersonal therapy sessions with a depressed female service user, demonstrated how the service user shifts the way they constructs the self and their mother during therapy. Moreover, the service user employed the subject positions 'dutiful daughter', the 'bad mother' and the 'damaged child'. During therapy the service user gradually adopted the therapist's subject positions, demonstrating how problem formulations and subject positions are

jointly negotiated (Madill and Barkham, 1997). Burck *et al* (1996) found that individual family members utilise a wider range of subject positions regarding the central theme by the end of therapy. Furthermore, Diorinou and Tseliou (2014) identified a shift from homogeneity to heterogeneity in family members' voices which legitimised the existence of different viewpoints. These studies assume that therapeutic change is associated with the service users increased ability to flexibly adopt a wider range of subject positions. In addition to this Frosh *et al* (1996) and Karatza and Avdi (2011) postulated that the service users' ability to flexibly adopt subject positions could be considered an outcome variable of psychotherapy. However, this assumption again sits uneasily with the theoretical underpinnings and aims of discursive psychology.
Another group of studies examined the negotiation of agency in therapeutic interactions by focusing on subject positions that accomplish control (Ayashiro, 2016; Avdi, 2005; Burck *et al* 1998; Burman, 1992; Burman, 1995; Guilfoyle, 2001; Guilfoyle, 2002; Kogan, 1998; Kogan and Gale, 1997; Madill and Barkham, 1997; Madill and Doherty, 1994; Roy-Chowdhury, 2003; Soal and Kottler, 1996). These studies postulate that subject positions that accomplish control are associated with psychological wellbeing and present the emergence of these subject positions as evidence of therapeutic change (Avdi, 2005; Burck *et al* 1998; Guilfoyle, 2002).

For example Avdi (2005) conducted a discourse analysis of systemic family therapy with a child diagnosed with autism. It examined shifts in the ways agency is constructed and discursively negotiated. At the start of therapy there was a dominance of medical discourse which positioned the child as lacking agency. This was gradually shifted to allow alternative, less problem-determined dialogue to emerge; such as restoring the notion of the child as a competent social agent. This shift was postulated to reflect an important aspect of change in therapy and argue that a psychiatric diagnosis objectifies the service user and reduces agency. Additionally, Burck *et al* (1998) examined the process of enabling change in systemic family therapy and how the therapist functions to shift the family's construction of difficulties (the parents' lack of control over their children) from a discourse of 'being out of control' to 'being in charge'. Further to this, a study by Guilfoyle (2002) which discursively examined systemic family therapy sessions over a seven year period, demonstrated how at the start of therapy, family members constructed the son's problematic behaviour as driven by forces beyond his control. The therapist, through a variety of rhetorical strategies, constructed the son as an agent, and actively encouraged the family to accept this. Later in the therapy, the family presents this subject position, as a fact that the therapist enabled them to see.

With the aim of identifying early markers of outcome, Madill, Sermpezis and Barkham (2005), discursively examined four good and poor outcome psychodynamic therapy transcripts. Here good outcome therapy was defined as sessions which reduced service users' symptomology. In the good-outcome transcripts there was use of subject positions that accomplish control , whereas this was lacking in the poor-outcome therapy transcripts. In support of this, a discourse analysis of a therapy session in Japan found that the therapist's interpretation of the service user's dialogue, led to a denial of the service user's agency. This lack of agency was accomplished by trivialising the service user's suffering and preventing the service user from gaining ownership of their distress (Ayashiro, 2016). These studies postulate that subject positions that accomplish control are associated with psychological wellbeing. Therefore the emergence of subject positions that accomplish control in therapeutic interaction is presented as evidence of therapeutic change.

Discourse analytic studies often acknowledge the importance of the social context of therapy and the wider discourses in which therapy operates and often reproduces (Avdi and Georgaca, 2007). The final group of studies examine subjectivity from this perspective. Focusing on wider discourses regarding: gender (e.g. Burman, 1992, Burman, 1995; Kogan, 1998); family (e.g. Soal and Kottler, 1996), medicine (e.g. Avdi, 2005; Lester, 2014); culture (e.g. Roy- Chowdhury, 2010; Roy- Chowdhury, 2003; Singh, 2009; Soal and Kottler, 1996) and wider discourses regarding psychotherapy itself (Moore and Seu, 2010; Guilfoyle, 2001; Stancombe and White, 1997).

Medical discourse, as shown in chapter four, is prominent in lay individuals' and professionals' discourse regarding the construction of depression. It is also a focus of discourse analytic research regarding therapeutic interactions. Studies have examined the 'lay' and 'expert' discourses service users employ when constructing their accounts and pursuing therapeutic aims. The subject positions associated with medical discourses include "'patient" and "abnormality"; both of which function to pathologize human distress and limit possibilities for change (Avdi and Georgaca, 2009; Lester, 2014).

A larger collection of discursive studies examine wider discourses regarding family, gender roles and culture. Suggesting that subject positions regarding gender and culture are implicated in the creation, maintenance and dissolution of psychological difficulties (Burman, 1992; 1995). Soal and Kottler (1996) analysed narrative family therapy

transcripts of a black family in South Africa. The family constructed western, middle class family values as universal. This positioned the family as deficient in relation to the family ideal and required them to reject aspects of their culture in order to position their family as meeting family ideals. Other studies highlight the negative consequences when therapy fails to consider dominant discourses regarding culture, whereby the therapist's values are implicitly assumed to be universal and are imposed on the clinical dialogue. Singh (2009) examined family therapy with south Asian and white British families and found that regardless of family dynamics the therapist constructed the notion of family as a two generation, two-parent unit. This construction of family was divergent with the how the service users constructed 'the family'. Similarly, Roy-Chowdhury (2010) analysed a family therapy session where the male partner is of Indian origin. The male partner's dialogue utilised cultural discourses regarding the therapist (who was constructed as an expert and akin to a family elder) and mental illness (which is constructed as a physical illness and a source of shame). The analysis highlights how the therapist sidesteps these issues and reinforces a Western view of therapy and mental illness. This de-contextualises the service user's dialogue from its cultural presuppositions and results in the silencing of the male partner. The majority of the studies reviewed above focused on systemic therapy which views culturally preferred ways of constructing reality as implicit in the creation, maintenance and dissolution of psychological difficulties. Thus the examination of the ways service users' negotiate wider discourses in therapeutic interaction is considered a useful focus of psychotherapy research (Avdi and Georgaca, 2007).

The above section highlights how service users construct and attend to subjectivity regarding the self, control, experience and wider cultural norms during therapeutic interactions. This demonstrates how a discursive methodology can effectively analyse the sensitive and complex discourses occurring during therapeutic interaction. This is because DP's anatomy of talk is finer than other qualitative methods as it examines the relationship between conversational structures and the actions being accomplished (Stokoe *et al* 2012).

5.3.4. Assessing The Therapeutic Process:

Although the role of the therapist is self-evidently important when discursively examining therapeutic interactions, the above literature often neglects the therapist and focuses on service users' discourse in psychotherapy. This could be because the

therapist's discourse is considered a tool for facilitating the service user's progress (Georgaca and Avdi, 2009). Thus the change in service user's dialogue is viewed as central and examined more frequently (Stiles, 1997). The following discursive literature examines the therapist's talk and centres on two main themes: the role of the therapist and the therapeutic relationship.

5.3.4.1. The Role of the Therapist:

One viewpoint on the study of the therapist's role relates to the extent to which therapists' interventions are in line with their psychotherapeutic paradigm (Burck *et al* 1998; Ferrara, 1992; Finlay and Robertson, 1990; Frosh *et al* 1996; Gale and Newfeld, 1992; Kogan, 1998; Lewis, 1995; Nye, 1994). These studies discursively examined how the therapeutic paradigm is translated into linguistic practice. Finlay and Robertson (1990) explored the use of 'quasi-direct discourse' in psychoanalytic psychotherapy (i.e. utterances that lie 'between' direct discourse; uttering one's own words and indirect discourse; quoting the talk of another). This form of talk was identified as a common discursive strategy in psychoanalytic therapy. It functions to demonstrate active listening, maintain neutrality, express thoughts and emotions on behalf of the service user and attribute meaning to the service user's dialogue. A discursive analysis of thirty-four therapy sessions found that the use of discursive strategies that elicited vulnerability, enabled more empathetic discourse from service users (Roberts, 2015). In addition to this, Ferrara (1992) and Lewis (1995) both examined the therapists' *conversational style* in psychodynamic psychotherapy. They highlighted how the therapist gradually adopted the service user's conversational style to create joint-productions. This style created empathy, conversational involvement and coherence, all of which are important factors in therapeutic success.

Other studies take a 'therapy-neutral' stance, in that they focus on the therapist's agenda and the therapist's influence, irrespective of the therapeutic paradigm (Burman, 1995; Kogan, 1998; Roy-Chowdhury, 2003). Couture (2007) and Kogan and Gale (1997) examined how therapists pursue a de-centring and co-authoring agenda, to facilitate a multi-authored narrative. Multi-authored narrative was utilised to accomplish forward movement after conversational impasses. Hutchby (2005, 2007) focused on the discursive construction of active listening, whereas others focused on the way therapists' discourse exemplified social injustice and contributed to the disempowerment of the service user (Kogan, 1998; Lavie-Ajayi and Nakash, 2015). Kogan (1998) demonstrated how the solution-focused therapist employs discursive

strategies to control the unfolding dialogue in couple therapy. More specifically, the solution proposed by the therapist pathologizes the female partner's actions and ignores her attempts to formulate a different position, thus reproducing traditional discourses of white, heterosexual marriage where the man should be in control. One common element of the above literature is the assertion that therapeutic competence is dependent on therapeutic change (Avdi, 2005; Couture, 2004; Kogan, 1998; Stancombe and White, 1997).

5.3.4.2. Therapeutic Relationship:

Another aspect of discourse analytic research regarding therapeutic interactions focuses on the therapeutic relationship. This has been examined in terms of linguistic interaction, compatibility and the joint construction of meaning. Studies also emphasise the therapist's ability to provide links between broad theoretical concepts and actual practice (Georgaca and Avdi, 2009). An examination of long-term psychoanalytic treatment focused on issues of power and authority within the therapeutic interactions. The analysis looks at the utilisation of heuristic discourse where the speaker narrates their experience to better understand it; verses negotiative discourses where the listener challenges the meaning the speakers' attributions for their experience, without the speakers' invitation. It was found that concerns regarding power and authority emerge when the therapist and service user engage in negotiative discourses to co-construct meaning. However, when the service user and therapist share narrative power, it facilitates the service user's ability to reconstruct their own narratives and engage in heuristic discourse. This sharing of narrative power was postulated as a marker for solid therapeutic alliance (Nye, 1998).

Roy-Chowdhury (2006) reviewed systemic therapy sessions and highlighted features of a robust therapeutic relationship. A good therapeutic relationship was presented as consisting of higher levels of participation, consensus concerning subject positions and appropriate conversational formats. The therapist's dialogue, in good therapeutic alliances, consisted of minimal acknowledgments and mirrored the lexical choices of the service user. Furthermore the therapist's questions were not challenged or resisted by the service user. A weak therapeutic relationship was characterised by problems of speaking, hearing and understanding. The therapist and service user utilised different lexical choices and demonstrated a lack of consensus. The service user exhibited low levels of engagement, responded to the therapist with dispreferred responses or did not answer the therapist's question. Another concept regarded as central to the therapeutic

relationship is resistance in therapy (Van Denburg and Kiessler, 2002). Resistance was found to be displayed through several linguistic features such as: low levels of speech activity, increased pauses, fewer acknowledgement tokens, increased first person pronoun use, high use of the passive voice and increased instances of interrupting and overlapping (Van-Denburg and Kiessler, 2002). Resistance was also found to be more evident at the beginning of therapy (Grabhorn *et al* 2005).

These studies demonstrate how discursive methodologies can be utilised to examine the interactional dialogue between the therapist and service user during therapeutic interactions. This again emphasises the appropriateness of using a discursive methodology to examine therapeutic interactions.

5.4 Cognitive Behavioural Therapy and Discourse Analysis:

The above literature demonstrates how discursive analysis can be effectively applied to the study of therapeutic interactions. However, this literature has focused on the analysis of systemic or psychoanalytic therapy transcripts. This could be because systemic and psychoanalytic therapy are influenced by constructionism and therefore fit with the epistemological view of discourse analysis. Although CBT and constructionism have philosophic similarities, such as CBT's emphasis on the role of the service users' interpretations of events, a limited amount of discursive literature has utilised discourse analysis to examine CBT transcripts.

The majority of discursive CBT literature focuses on service users' experiences of CBT and examines this retrospectively via a discourse analysis of interview transcripts (Beattie *et al* 2009; Messari and Hallam, 2003). A very limited amount of discursive literature focuses on therapeutic interactions. Mathieson *et al* (2016) assessed the frequency of metaphors in forty-eight CBT sessions. The therapists were found to utilise metaphors at a higher rate than service users. This was assumed to be because CBT is an active therapy that emphasises psycho-education and skill development which results in therapists using teaching analogies. For example "changing behaviour is *like learning to drive a car:* it becomes more automatic with practice". This study examined the use of metaphors but did not discuss what these metaphors accomplish in CBT.

Whilst there is considerable evidence to support the efficacy of CBT (Andrews *et al* 2003; Ellis *et al* 2003; Roth and Fonagy, 2005), little research has focused on how CBT is put into practice during therapeutic interactions. Beckworth and Crichton (2014) focus

on how homework is implemented during CBT sessions. Their analysis found homework to be a face-threatening act because it involves the discussion of potentially distressing material and is an imposition on the service user (Brown and Levinson, 1987). It examined how discursive strategies are employed to manage this issue. For example, the therapist and the service user utilised politeness strategies in explaining, delivering and reviewing homework. Other strategies included the interface between institutional and professional frames and the use of constructed dialogue.

5.5 Therapeutic Interactions and Depression:

In addition to the limited amount of discursive literature examining CBT transcripts, to date no discursive analyses have been conducted about depression in UK clinical settings. The discursive psychological studies noted below were conducted in Canada, New Zealand, Sweden and the USA (Gerorgaca, 2000; Lewis, 1995; Levitt, 2002). The majority of discursive examinations of therapeutic interactions between mental health professionals and service users with a diagnosis of depression have focused on treatment negotiations (Drew *et al* 1999; Teghtsoonian, 2009). To date no discursive research has focused on how service users and therapists jointly construct depression during therapeutic interactions or how CBT principles are constructed in interaction and how cognitive behavioural strategies are implemented and attended to during therapeutic interactions. Therefore this thesis will provide a unique perspective regarding the construction of depression and how therapeutic dialogue in CBT is constructed and what does it accomplish. This is because previous literature has focused on treatment negotiations during therapeutic interactions or conducted interviews regarding depression with individuals who sought treatment for depression. No research has looked at the construction of depression during CBT sessions nor have they utilised naturalistic data.

Finding an effective treatment for depression was also a focus of therapeutic discursive literature (Oliphant, 2009). Patients communicated their conceptual representations of distress at the outset of each therapeutic consultation. Three types of discourse were identified: those emphasising symptoms, those emphasising life situations and mixed discourses (Karasz *et al* 2012). Mental health professionals' decision making regarding pharmaceutical treatment was associated with the type of discourse the patients used to

construct their distress. Professionals made few efforts to persuade patients to accept biomedical attributions or treatments. Rather, common-sense decision-making algorithms emphasising the patients' views and preferences, guided the professionals' decision-making process (Karasz *et al* 2012). Biomedical discourse was used to construct depression as purely biological in origin and medication as the only effective treatment (Oliphant, 2009).

5.6 Synthesis:

The above research demonstrates how a discursive approach can be effectively utilised to examine therapy transcripts. It also attempts to bridge the gap between research and clinical practice. However, the research has some methodological shortcomings that should be noted. Firstly, many of the studies did not attend to or allude to criteria for achieving methodological rigor, such as: the use of exemplars, the inclusion of deviant case analysis and reflexivity (e.g. Stancombe and White, 2005; O'Reilly, 2007; Karatza and Avdi, 2011). Secondly the studies had a preference for analysing case studies or single therapy sessions which resulted in a limited data set (e.g. O'Reilly, 2007; Roy-Chowdhury, 2010; Strong *et al* 2010). Additionally there was a widespread lack of systematically defined research questions, making the aims of the studies ambiguous (e.g. Kogan and Gale, 1997; Couture, 2007; Avdi, 2005). There were also inconsistencies between the choice of method, epistemological orientations and knowledge claims (e.g. Avdi, 2005; Charles, 2012; Kogan and Gale, 1997). This often led to generalisations of the research findings beyond the scope of discourse analysis, and bold realist claims (i.e. claiming the existence of a phenomenon independent of interpretation). For example, numerous studies stated that the utilisation of particular discursive strategies demonstrated an improvement of psychological wellbeing (e.g. Avdi, 2005; Couture, 2007; Roy-Chowdhury, 2010). Some of these methodological shortcomings could be due in part to the lack of relevant literature or guidelines on how to conduct a discourse analysis.

5.7 Summary:

Chapter five demonstrates how a discursive approach can be effectively utilised to analyse the sensitive and complex discourses occurring during therapeutic interactions. This is because DP has a sophisticated sense of the relationship between actions and the

conversational structures that accomplish them (Stokoe *et al* 2012). This emphasises the appropriateness of using a discursive methodology to examine therapeutic interactions. Chapter five also demonstrates how to date no discursive analyses have been conducted regarding the construction of depression in UK therapeutic settings. In addition to this a limited amount of studies have employed a discursive methodology to examine CBT and even fewer have analysed CBT therapy transcripts. This highlights the need for a discursive analysis of therapeutic interactions between service users and therapists, during CBT sessions for depression.

5.8 Aims and Research Questions:

5.8.1. Overall Summary of Literature Review:

Overall this literature review demonstrated why a discursive approach to examining depression and therapeutic interactions between therapists and service users in CBT sessions for depression is necessary. It also provided a detailed review of previous literature and highlighted current gaps in this literature.

Chapter one diachronically reviewed how depression has been constructed and understood, and the changes that the term depression has undergone overtime. Therefore, how depression is understood is dependent on the historical specificity of knowledge. This has implications for professionals and lay-individuals' understanding of depression and could influence how individuals discursively construct depression. More recently, formal classification systems have been developed to categories depression. However the main classification systems, the DSM and ICD, differ in their classification of depression. The lack of homogenisation between the DSM and ICD emphasises the importance of taking a discursive approach to the literature because to date there is not one universal definition of depression. The current thesis therefore aims to discursively examine therapeutic interactions between service users and therapists during CBT sessions for depression. Chapter one concluded by examining how the cognitive model conceptualises depression. It also provided an overview of CBT aims, CBT strategies and mechanisms for change and the generic structure of a CBT session. This overview provides the reader with a basic understanding of CBT and therapeutic practice.

Chapter two reviewed the qualitative research regarding depression. This research largely adopted narrative analysis and corpus linguistic techniques (Kuhnlein, 1999; Levitt, 2002) and has highlighted how individuals construct depression by focusing on word usage. It demonstrated how individuals with a diagnosis of depression have a tendency to engage in negative verbal behaviour; frequently borrow terminology from psychological and medical discourse; use metaphors to communicate experience; and utilise more first person pronouns. Two key constructs that were identified in non-discursive research are, "*I am depressed*" relating to negative life events or "*I have depression*" relating to pathology originating from the individual (Harvey, 2012; Rude *et al* 2004). Qualitative research provides an insight into how depression is constructed. However, the use of narrative analysis and corpus linguistic techniques means that the analysis does not provide any details regarding what these constructions are used to accomplish, or how they are attended to by others. The research has simply highlighted that these ways of talking about depression exist. This highlights the need for a discursive analysis of the construction of depression because discursive analysis of talk is finer and has a sophisticated sense of the relationship between actions and conversational structures that accomplish them (Stokoe *et al* 2012: 2).

The theoretical perspective adopted in the current research is discursive psychology (DP). A DP perspective is adopted because DP shows how actions are accomplished through discourse (Edwards and Potter, 2001). This is pertinent with regards to therapeutic settings where therapy is constructed and achieved through discourse. Adopting a DP perspective ensures that the discourse used in CBT sessions is seen as central. It also ensures that the discourse is viewed as a topic rather than resource. DP offers a fertile scheme for interpreting and making sense of psychological talk (Edwards and Potter, 1992). Chapter three discussed social constructionism, highlighted the key features of DP and argued how DP can be utilised effectively in the current research project.

Chapter four explored how print-media, lay individuals and professionals construct depression. It found print media often associated mental illness with violence, dangerousness and unpredictability which promoted stigmatisation. Additionally public texts often constructed individuals with a diagnosis of depression (particularly women) as blameworthy and in control of their illness and portrayed depression as the result of a biological deficiency. The utilisation of biomedical discourse to construct depression was a prominent finding of discourse analytic research. Mental health professionals tend

to draw upon biomedical discourse to justify treatment choices whereas service users utilised biomedical discourse to construct and legitimise accounts and experiences. Depression was also constructed as a gendered disorder, a personal weakness and intrinsically immersed in the social context of individuals' lives. Examinations of recovery discourse highlighted how individuals construct their depressed and non-depressed identity to manage accountability for depression and construct normality. To date mental health professionals' and service users' constructions of depression have been examined separately and retrospectively via interview, and have focused on explanatory frameworks, treatment choices and diagnosis. No research has looked at how depression and identity are jointly constructed and attended to during therapeutic interactions. Furthermore, previous discursive studies have not examined how identity is constructed by individuals currently seeking help for depression. Instead, they focused on how individuals who had a previous episode of depression constructed identity in recovery discourse.

In addition to this, to date no discursive analyses have been conducted regarding the construction of depression in UK therapeutic settings. A limited amount of studies have employed a discursive methodology to examine psychotherapy and even fewer analyse therapy transcripts (Avdi and Georgaca, 2007). Chapter five reviewed the studies that employed a discursive methodology to analyse transcripts of psychotherapy sessions. It found that the majority of literature examined systemic or psychoanalytic therapy transcripts and focused on four themes: the attribution of blame; subjectivity; the role of the therapist and the therapeutic relationship. A limited amount of discursive literature has utilised discourse analysis to examine CBT transcripts. The majority of discursive CBT literature focuses on service users' experiences of CBT and examines this retrospectively via a discourse analysis of interview transcripts. The studies that have analysed therapy transcripts focused on metaphor use and the implementation of homework. Discursive examinations of therapeutic interactions between mental health professionals and service users are limited, and have focused on treatment negotiations regarding depression (Drew *et al* 1999; Teghtsoonian, 2009). Furthermore, many of the discursive studies have methodological shortcomings and make realist claims that do not fit with the theoretical underpinnings and aims of DP.

5.8.2. Rationale:

The changing conceptualisation of depression over time and the lack of a universal definition of depression, emphasises the importance of taking a discursive approach to the literature; in order to determine how depression is conceptualised. The qualitative research regarding depression highlights the need for a discursive analysis of the construction of depression. This is because a discursive analysis of talk is more detailed and examines the relationship between actions and conversational structures (Stokoe *et al* 2012: 2). Furthermore, a DP perspective ensures that the discourse used in CBT sessions is seen as central by ensuring that the discourse is viewed as a topic rather than resource. DP offers a fertile scheme for interpreting and making sense of psychological talk (Edwards and Potter, 1992).

Previous literature demonstrates how a discursive methodology could be effectively utilised to examine constructions of depression and be applied to therapeutic interactions. It has also highlighted gaps in the literature. To date mental health professionals' and service users' constructions of depression have been examined separately and retrospectively via interview. No research has looked at how depression is jointly constructed and attended to during therapeutic interaction. Furthermore, previous discursive studies highlight how individuals who previously had a depressive episode construct identity but do not examine how identity is constructed by individuals currently seeking help for depression. None of the studies examined how identity is constructed during therapeutic interactions. In addition to this, no discursive analyses have been conducted regarding the construction of depression in UK therapeutic settings. A limited amount of studies have employed a discursive methodology to examine psychotherapy and even fewer analyse therapy transcripts. Lastly, only a limited amount of discursive literature has utilised discourse analysis to examine CBT transcripts. The majority of discursive CBT literature focuses on service users' experiences of CBT. Discursive examinations of therapeutic interactions between mental health professionals and service users are limited and have focused on treatment negotiations for depression. Therefore, although a discursive methodology has been deemed appropriate for the examination of therapeutic interactions between therapists and service users in CBT sessions for depression, to date no research has discursively examined this.

5.8.3. Aims and Research Questions:

The overall aim of this thesis is to discursively examine therapeutic interactions between therapists and service users during Cognitive Behavioural Therapy sessions for depression. The specific research questions are designed to collaboratively deliver this aim.

- How is therapeutic dialogue constructed and what does it accomplish?
    - How are CBT strategies constructed in therapeutic talk?
    - How are CBT strategies implemented during CBT sessions?
    - How are CBT strategies attended to?

These research questions were developed because chapter five demonstrated that a limited number of studies have employed a discursive methodology to analyse CBT therapy transcripts and that to date no discursive research has looked at how CBT strategies are implemented and attended to.

- How is depression constructed in CBT sessions?

This research question is necessary because chapter one demonstrated that the way depression has been constructed and understood in psychology and psychiatry varies, and that the DSM and ICD currently differ in their classification of depression. Therefore research needs to be conducted around how depression is constructed in talk. In addition to this to date no research has looked at how depression is jointly constructed and attended to during therapeutic interaction.

- What do the constructions of depression accomplish within therapeutic interactions?
    - How are constructions of depression attended to within therapeutic interactions?

- How are constructions of depression utilised to construct identity, manage accountability and legitimise behaviour and distress?

These research questions were chosen because chapter two highlighted how current qualitative research provides an insight into how depression is constructed. However, the use of narrative analysis and corpus linguistic techniques, mean that the analysis does not provide any details regarding what these constructions of depression are used to accomplish or how they are attended to by others.

- How is identity constructed and attended to during therapeutic interactions, for depression?

    - What do constructions of identity accomplish during therapeutic interactions?

    - How does an understanding of the way identity is constructed and attended to during therapeutic interactions, aid clinical practice?

These research questions were generated because chapter four highlighted gaps in previous discourse analytic research regarding depression. For example, previous discursive studies highlight how individuals who had been diagnosed with depression in the past construct identity, but do not examine how individuals currently seeking help for depression construct identity during therapeutic interactions.

Specific research questions are addressed in particular chapters. For example, chapter nine addresses the research question "how are the terms "depressed" and "depression" utilised during therapeutic interactions?" by conducting a deviant case analysis on the occasions the terms are utilised in therapy. Some of the wider aims and questions are addressed across the whole analysis. For example, "How is depression constructed in CBT sessions?" is a question that is addressed across the whole analysis.

Chapter Six -Methodology:

6.1 Overview:

In the thesis it has been established that discursive psychology is the most appropriate approach to explore therapeutic interactions between service users and therapists during CBT sessions for depression. The method associated with discursive psychology is discourse analysis (DA). Therefore, a discourse analysis will be conducted on the recordings of CBT sessions. In the methodological approach section (6.2 below), the key concepts of DA, and why it was chosen as the methodological approach in the current research project will be discussed. In section 6.3, 6.4, 6.5 and 6.7, the data and sample used within the current research project are explicated. It will also detail why using naturalistic data, such as recordings of CBT sessions, are beneficial and superior to other data sources. In section 6.6 Attention is paid to the ethical considerations. In section 6.8 conducting the analysis, a discussion on how the data will be analysed is presented. Finally, the chapter will conclude with the sections 6.9 participant orientations and 6.10 generalisability of findings.

6.2 Methodological Approach:

Discursive psychology views language as a social action (Edwards and Potter, 1992). It is concerned with what people do with language and how people negotiate meaning through linguistic interaction (Coyle, 2015). The form of discourse analysis developed within discursive psychology addresses the social functions of talk and considers how these functions are achieved. It does this by examining how actions are accomplished in language and how actions operate through language. The form of discourse analysis developed within discursive psychology was conducted on the recordings of CBT sessions to explore therapeutic interactions between service users deemed to be suffering from depression and therapists during CBT sessions. A discursive approach was employed as it can account for the complexity and variability of the data (Edwards and Potter, 1992; McGuire, 1986; Burck, 2005). It is also inductive and aims to provide rich and illuminating insights into the phenomenon under investigation (Edwards and Potter, 1992; Trafimow, 2014).

6.2.1. Discourse Analysis (DA) in the Current Research:

Discourse analysis emphasises and tries to account for the detail, complexity and inter-changeability of discourse (Every and Augoustinos, 2010). Unlike other qualitative methods, discourse analysis focuses on what discourse accomplishes, rather than focusing on internal motives or feeling (Edwards and Potter, 1992). Therefore discourse analysis can be utilised to focuses on how talk of internal states are rhetorically presented, constructed and utilised. The current methodological approach views discourse as action orientated, situated and constructed (Edwards and Potter, 2001). These key features of discourse are considered below.

6.2.1.1. Discourse is Action Orientated:

DA focuses on the *action orientation* of talk and text (Edwards and Potter, 1992). Action orientation is different to the 'speech act approach' in linguistics; that assumes that a discrete set of words correspond to a discrete act, such as promising, inviting and commanding (Searle, 1975). Furthermore, discourse is not viewed as the outcome of mental states and cognitive processes but a domain of action in its own right (Edwards and Potter, 2001). DA is interested in the performative nature of talk and how language is used to construct social reality and psychological phenomenon (Wetherell, Taylor and Yates, 2009; Edwards and Potter, 1992; Edwards and Potter, 2001). From this perspective, discourse concerning depression is not assessed to ascertain whether or not the speaker is depressed, but is instead assessed to see what actions talk about depression performs. For example discourse is not viewed as reflecting an individual's psychology but is thought to do something (Wetherell, Taylor and Yates, 2009). It is what is being done that is of interest; for example fact construction, protection of the speaker's stake and interest, and to manage accountability for their situation (Edwards and Potter, 1992 and Wetherell, Taylor and Yates, 2009).

6.2.1.2. Discourse is Situated:

Discourse analysts hold the assumption that discourse is variable and dependent on the context in which it is constructed (Gilbert and Mulkay, 1984). This notion is often referred to as discourse being situated or occasioned. Discourse is deemed to be situated or occasioned in three ways. Firstly, it is organised sequentially, in that a new

utterance to related to the dialogue that came before it and the new utterance also sets up (but does not determine) the dialogue that precedes it (Hepburn, 2007). Secondly, it is situated institutionally, in that the institutional identities (in the current analysis this would be therapist and service user), and the task, (in the current analysis this would be CBT), are relevant to what takes place (Hepburn, 2007). This is because discourse is regarded as embedded in the processes of interaction (Edwards and Potter, 2001). DA demonstrates that discourse is orientated to, but not determined by its setting and sequential position (Edwards and Potter, 2001). For example, a question is usually followed by an answer. Thus a question provides an answer with normative relevance. However, an answer is not an inevitable or necessary response, as answers can be deferred or withheld (Heritage, 1984). Similarly the talk that occurs in institutional settings such as CBT sessions may or may not, relate to mental health issues (Schegloff, 1997). The producer of the discourse makes institutional activities and identities relevant by invoking and orienting to them (Edwards and Potter, 2001). Lastly, discourse is situated rhetorically, in that any description can be examined for how it counters relevant alternative descriptions (Hepburn, 2007). Therefore, discourse is regarded as pervasively rhetorical (Billig, 1987). For example discourse is designed to counter alternative versions and resist attempts to disqualify the producer's version as false (Edwards and Potter, 1992). Therefore, discourse can include both defensive and offensive rhetoric (Potter, 1996). When individuals offer an evaluation they are typically countering another evaluation (Billig, 1991). Therefore, alternative perspectives and lines of argument shape evaluative discourse (Hepburn, 2007).

DA takes into account the sequentially, occasioned, situationally orientated and rhetorically designed nature of discourse. Hence, in an institutional setting such as CBT sessions, DA's focus would be on how depression is introduced, defined and made relevant within the therapy session. Furthermore, talk about depression could be viewed as an agenda of the CBT session.

6.2.1.3. Discourse is Constructed and Constructs:

Discourse is treated as constructed and constructive (Hepburn, 2007). For example, DA is concerned with the way discourse itself is constructed. It analyses how particular words, metaphors, idioms, rhetorical devices, descriptions, accounts and stories, are drawn on and constructed, in interactional discourse (Edwards, 1994; Edwards and Potter, 2001). However, DA is also concerned with the way discourse is used to

construct particular versions of the world. It examines how versions of life, circumstance, history, social groups and psychological phenomenon are constructed to do particular things during interaction. Therefore, DA studies the actions accomplished with the construction and the way these constructions are built as factual, objective and independent of the speaker (Edwards and Potter, 2001).

6.2.2. Why DP Discourse Analysis (DA) was Chosen Over Other Forms of DA:

Discourse analysis (DA) is an umbrella term used for a variety of discursive approaches to analysing text (Nikander, 2008). In basic terms, DA deals with naturally occurring language use, rather than the language system and it focuses on units of language, rather than isolated words (Wang, 2013). The term discourse has a number of meanings depending on the theoretical tradition. There are four main categories into which definitions of discourse could be characterised (Schiffrin *et al* 2001; Wang, 2013). In linguistics, discourse is defined as anything beyond the sentence. The study of discourse is defined as the study of language use. In the linguistic paradigm of DA, discourse refers to a broad conglomeration of linguistic and non-linguistic social practices and ideological assumptions that together construct power. In the framework of social constructionism, discourse is defined as the place where particular versions of reality are descriptively constructed (Burr, 1995; Edwards, 1997; Jones, 2012; Schiffrin *et al* 2001; Wang, 2013). For the purposes of this thesis when using the term discourse analysis it will be referring to the approach used within DP, which Potter (2003) defines as "the study of how talk and text are used to perform actions" (Potter, 2003: 01).

In addition to the type of DA used within DP, there is also Foucauldian Discourse Analysis (FDA) and Critical Discourse Analysis (CDA) (Ankaki *et al* 2003). The discourse analysis adopted in the current research is often distinguished and compared with FDA because these are the two most commonly used within psychology, as opposed to other disciplines (Burr, 2003; Parker, 1997). Despite the similarities where both DA and FDA do not view discourse as a route to accessing cognitive states and do not focus on internal motives or feelings (Burr, 2003; Parker, 1997; Smith, 2008), there are sometimes tensions between these different traditions and the styles of work associated with them. DP discourse analysis was chosen over FDA because they differ in terms of their focus of enquiry. FDA is less oriented to interactional discourse (Bloomaert and Bulcaen, 2000) whereas, DA focuses on the action orientation of talk and text; what a

particular account is 'doing' within the interaction (Edwards and Potter, 1992). Furthermore, DA was chosen over FDA because FDA is less focused on the individual producing the discourse and more interested in the broader cultural and political influences involved. Whereas, DA is concerned with the activities within interaction, what a particular account is 'doing' within the interaction and what 'discursive devices' are being employed (Edwards, 1997). DA is also interested in how language is used to construct social reality and the phenomenon; in this case depression (Wetherell, Taylor and Yates, 2009). DA is concerned with what 'discursive devices' are being employed and tries to identify how depression is rhetorically presented, constructed and utilised (Edwards, 1997).

6.2.3. Summary:

DA was particularly suitable for the current research as recordings of CBT sessions provide a wealth of naturally occurring data; which is favoured by discursive psychologists (Edwards and Potter, 1992; Potter and Hepburn, 2005). Furthermore, interactional discourse in the form of CBT sessions is ideal data for discourse analysis. The recordings of CBT sessions centre on the interactions between the service user (deemed by the PHQ-9 to have depression) and the trainee therapist. DA can be used to account for the detail, complexity and inter-changeability of therapeutic and depression discourse (Every and Augoustinos, 2010). DA can also be used to effectively identify in detail how therapeutic interactions work and how depression is constructed. Therefore, the aims of the current research and the data used, lend themselves to using DA.

6.3. The Data:

The data in this research are recordings of sixteen CBT sessions. Each session was one hour long and was led by a trainee Improving Access to Psychological Therapies (IAPT) therapist between January 2015 and December 2015. The CBT sessions were conducted face to face and are already recorded for training purposes. The data therefore consists of institutional talk. Institutional talk differs from more informal talk in three ways. Firstly the interaction involves the individuals in context specific goal orientations, which are tied to their institutional identities i.e. therapist and service user. Secondly, the interaction involves constraints on what will be treated as allowable contributions

to the business at hand. Lastly, the interaction is associated with inferential frameworks and procedures that are particular to a specific setting (Heritage, 2005: 106).

These recordings represent 'naturalistic data', which Potter (1996, p.135) defined as data that would exist and remain the same if the researcher had not conducted the study. This means the conversations would have occurred even if the research had not been conducted (Taylor, 2001:27). However, no talk can be entirely 'natural' as it is always mediated by the context of the occasion in which it is generated (Griffin, 2007; Edwards and Potter, 1992). Potter defined naturally occurring talk as 'spoken talk that is produced entirely independently of the actions of the researcher' (Potter, 1997:148). However this definition is not straightforward, it would be more accurate to describe data on a continuum from 'empirical interaction in the laboratory to more real interaction happening naturally out in the world' (Potter, 1997:149). Therefore the data is 'naturalistic' rather than 'natural'. However, the data is as natural as it can be because the recordings would have been recorded irrespective of the research so any 'effect' the recording had on the interaction would have occurred anyway. For example Potter suggested a "(conceptual) dead social scientist's test: would the data be the same, or be there at all, if the researcher got run over on the way to work? An interview would not take place without the researcher there to ask the questions; a counselling session would take place whether the researcher turns up to collect the recording or not" (Potter, 2002: 541). The aim of using naturalistic data is to 'avoid active researcher involvement, even if the full realisation of this ideal is often impossible' (Potter and Hepburn, 2005: 48).

The benefits of using naturalistic data, such as the recordings of CBT sessions, are that the interactions between the service user and the therapist are not influenced by the researcher's agenda (Potter, 2004). Furthermore, the service user and therapist's stake and interest are demonstrated through their interaction and are not influenced or created by the researcher (Potter and Hepburn, 2005). Therefore naturalistic data allows for the identification of important elements of talk without influencing the dialogue (Goodman and Speer, 2015). The current data also avoids cognitivism because unlike qualitative interviews, the service user and therapist are not required to offer abstract conceptual rumination (Potter, 2003). Again, unlike qualitative interviews, recordings of CBT sessions can allow for the generation of novel questions and issues (Speer, 2002) and is also better at examining what occurs within the session than retrospective accounts that are limited by memory, attention and perception.

Because the CBT sessions were recorded for training purposes, no researcher intervention was required, and no additional ethical risks were imposed on the service users or therapists (participants). This is because they did nothing different or extra on top of the existing therapy session other than provide their consent to allow access to the recordings. As IAPT is open to anyone with anxiety and/or depression, this enabled the potential for a diverse sample of service users.

There were two inclusion and exclusion criteria imposed on the data. Firstly, the service user had to score higher on the patient health questionnaire (PHQ-9), which measures depression, than on the generalised anxiety disorder questionnaire (GAD-7), which measures anxiety. This was to ensure the therapeutic interactions were between therapists and service users deemed to be suffering from depression. Secondly, English had to be the service users' first language. This exclusion criteria does however screen out some of the diversity from the sample. However, this was imposed because the transcription of the session, where the first language was not English, was too complex and the essence of what was being said was lost through hesitation and misuse of grammar and specific words.

6.4. Sample:

6.4.1. The IAPT Service User:

IAPT is an NHS initiative and is currently the leading service provider for depression treatment in the UK. It aims to increase and promote access to talking treatments, such as CBT for depression and anxiety (Hammond *et al* 2012). IAPT is open to anyone with mild to moderate anxiety and/or depression. The service users included in the data are individuals who received CBT via the IAPT service between January 2015 and December 2015. In total nine service users agreed to participate in the research. This consisted of eight female service users and one male service users. A range of religious beliefs, ethnic backgrounds and occupations were represented. Limited demographic information was collected to limit researcher interfere in order to keep the data as naturalistic as possible. The demographic information collected was via the recordings and therefore not all service users' demographic information was made relevant within the dialogue and thus could not be ascertained. This was not deemed to be an issue because this

information was not salient to the analysis of therapeutic interactions. Jowett (2016: 4) suggested that demographic information about the speaker is arguably of less interest to discursive researchers, than the way in which the speaker constructs an identity within the interaction itself.

The research aimed to discursively examine therapeutic interactions between therapists and service users deemed by the PHQ-9 to be suffering from depression. The PHQ-9 is a self-administered patient questionnaire for screening, diagnosing, monitoring and measuring the severity of depression. The PHQ-9 incorporates DSM-IV depression diagnostic criteria and other leading depressive symptoms into a brief self-report tool. The GAD-7 is also a self-administered patient questionnaire that is used to identify probable cases of generalised anxiety disorder and assess symptom severity. The GAD-7 incorporates DSM-IV diagnostic criteria for anxiety and other leading anxiety symptoms into a brief 13 item self-report scale. Although the research was taking a constructionist approach, quantitative scores from the GAD-7 and PHQ-9 were used to ensure that depression/depressive symptoms was an issue of salience to be addressed within the sessions and subsequently include or exclude recordings from the research. There are five main reasons for this. Firstly, although the PHQ-9 and GAD-7 are quantitative measures, at this current time there is no workable definition of depression and the categories depressed and non-depressed are constructed through classification systems such as the DSM. Therefore, the PHQ-9 and GAD-7 are based on current conceptualisations of depression in the western world. Additionally, the PHQ-9 and GAD-7 are the only measure of depression and anxiety within the IAPT service and are already being given to service users to complete as part of the CBT session. Therefore, to ensure the data collected is free from any researcher intervention and remains naturalistic, these scores were the quickest way of screening the data. Furthermore, the service users were made aware of their PHQ-9 and GAD-7 scores at the start of each CBT session. They were also aware of what the scores indicated, thus making them discursively relevant to the analysis. This is particularly important with regards to chapter eight which demonstrates how service users and therapists orient to depression but the terms “depressed” and “depression” are absent from the dialogue.

For this research project, recordings of CBT sessions were sourced from individuals, with higher PHQ-9 scores indicating depression than GAD-7 scores indicating anxiety, who have been referred to the IAPT service between January 2015 and December 2015. This is not to say that service users have depression and or anxiety but rather that

depression/depressive symptoms were an issue of salience to be addressed within the sessions. Moreover, all service users had PHQ-9 scores that indicated the presence of depression according to the PHQ-9 which is how therapists within the IAPT service would define depression. Therefore this is the definition used by the therapist.

Due to data sharing concerns regarding access to service users PHQ-9 and GAD-7 scores, the Course Director of the CBT PGDip[3]/MSc programme at Coventry University was responsible for including or excluding recordings from the research. This was based on the inclusion criteria detailed above and ensured the anonymity of the service users were protected as the GAD-7 and PHQ-9 scores remained confidential.

6.4.2. The Trainee CBT Therapist:

The CBT PGDip/MSc programme is an integrated one-year postgraduate course leading to a professional qualification as a High Intensity Psychological Therapist. The course has been developed as a partnership between Coventry University and NHS Trusts; and is funded by Health Education West Midlands. The course has a cognitive behavioural theoretical base. It aims to provide practical, intensive and detailed skill training to facilitate skill development to a defined standard of competence. The course also aims to increase the trainees' knowledge base of theory and research in CBT, and promote a critical approach to the subject. It aims to equip trainees to become skilled and creative independent CBT practitioners (IAPT, 2011).

Training as a High Intensity Interventions therapist on the CBT PGDip/MSc programme is open to qualified mental health professionals; normally possessing at least an upper second-class degree or evidence of ability to study at postgraduate level or the professional equivalent. In addition, applicants need to have at least one year of post qualification experience in mental health; preferably with some experience of supervised practice in CBT. Trainees admitted to the training will normally possess a recognised core professional training in a mental health related field. However, some applicants may have attained the required professional competences and knowledge via a non-traditional employment and training route. The relevance of this employment and training is assessed via the BABCP framework.

[3] Postgraduate Diploma (PGDip)

The trainee therapists included within the research were individuals who enrolled on the one year CBT PGDip/MSc programme at Coventry University between January 2015 and December 2015. In total eleven trainee therapists agreed to participate in the research. This consisted of ten female therapists and one male therapist.

6.4.3. Sample Size and Representativeness:

Overall the sample size is moderate and in line with other discursive research. For example, Lofgren *et al* (2015) had a sample size of eleven clinical psychologists when discursively examining how mental health practitioners conceptualise mental health, during semi structured interviews. Furthermore, the data was collected from a hard to reach group which makes large data collection difficult to accomplish. In addition to this the guiding principle regarding sample size in this thesis was the concept of saturation (Glaser and Strauss, 1967). Whereby, data collection stopped when the collection of new data did not shed any further light on the issues under investigation (Mason, 2010). This is because DA is concerned with meaning and not making generalised hypothesis statements (Crouch and McKenzie, 2006).

To ensure the data remained naturalistic, no research intervention occurred between the service user and researcher, except via the participant information sheet. This means that a limited amount of demographic information was collected because all demographic information was acquired via the recordings. Furthermore, although the research employed a diverse sample, some of this diversity was screened out because recordings from individuals whose first language was not English were excluded from the data set. This exclusion criteria creates limited representativeness. It was imposed because the transcription of these sessions, where the first language was not English, was too complex and the essence of what was being said was lost through hesitation and misuse of grammar and specific words. Furthermore the sample consisted of trainee therapists, predominately female service users and participants whose first language is English. This again has implications regarding the transferability of the findings which is discussed in more detail is section 6.10. Although the sample could have implications for transferability it was representative of the trainee therapists enrolled on the CBT PGDip/MSc programme at Coventry University and service users accessing the service between January 2015 and December 2015.

6.4.4. Recruitment of Participants:

The research utilised opportunity and snowballing sampling techniques to recruit therapists and service users. The therapists were approached because they enrolled onto the CBT PGDip/MSc programme at Coventry University in January 2015. The therapists that agreed to participate in the research then asked each of their IAPT service users if they would be happy to participate in the research.

The therapists and service users were given a participant information sheet (see appendix 2 and 3) that detailed the purpose of the research and what the recordings would be used for. Therapists and service users were told that the aim of the research was to conduct a service evaluation of the IAPT service. They were informed that the recordings would be used to allow professionals and academics to gain an understanding of the way in which individuals seeking support for their mental health problems negotiate with service providers. They were informed that participation would be kept anonymous and that anonymised quotes may be used as part of the research. They were also informed that the results of the research would be written up as part of a PhD thesis, for publication in peer-reviewed journals and/or presented at academic conferences.

6.5. Data Collection Method:

The therapists recorded their CBT sessions as a matter of routine for training purposes. As the data in the study is "naturalistic" data, no specific methods for data generation were employed. The recordings were given to the course director, who screened the data for service users whose main presenting problem was depression, based on the inclusion criteria stated above. This ensured the anonymity of the service user was protected and that no unauthorised data sharing occurred.

6.6. Ethical Considerations:

As the data was already collected for training purposes, this project posed no new ethical risks for service users and therapists. However, to protect the service users' and therapists' anonymity, service users were given pseudonyms. Both the IAPT service user and the trainee therapist gave informed consent before participation (see appendix 2

and 3 for a copy of the participant information sheets). Furthermore, before the research began, gatekeeper permission was gained from the Course Director of the Cognitive Behavioural Therapy PGDip/MSc programme at Coventry University.

As mentioned above, due to data sharing concerns regarding the scores from the PHQ-9 and the GAD-7, the Course Director of the CBT PGDip/MSc programme at Coventry University screened the data before it is passed on for analysis. This is to ensure all PHQ-9 and GAD-7 scores are kept confidential and the anonymity of the service users and therapists are fully protected. Coventry University's ethics committee approved the current research project on the 11th November 2013 (see appendix 4).

Although the current research poses no new ethical issues as the CBT sessions are already being recorded for training purposes, there are still general ethical issues regarding recording therapy sessions and what is done with the recordings. Firstly all the service users and therapists were informed that extracts from the recordings would be written up as part of a PhD thesis, for publication in a peer-reviewed journal and/or presented at an academic conference. Secondly, to ensure data protection, the recordings will be stored securely in a locked cabinet in a locked office in accordance with the Data Protection Act 1998. The recordings will only be used for research and training purposes. Furthermore, the lead researcher and the supervisory team will be the only individuals viewing the recordings. The recordings will be kept until the research purposes have been met. After this the recordings will destroyed in accordance with Coventry University's data protection policy. Thirdly, the recordings of CBT sessions are likely to contain sensitive information. Any safeguarding concerns were to be discussed with the course director. All personal information was made anonymous or omitted from the final analysis write up. For example, in order to maintain anonymity the therapist's name has been omitted from the extract and replaced with *therapist*. Furthermore, the recordings of the trainee therapist will only be used for research purposes. The recordings will not be used as part of the therapist's assessment and subsequently not impact upon their attainment of a CBT PGDip/MSc unless they themselves voluntarily submit the recording for assessment. Lastly although the research poses no new ethical issues there are general ethical implications regarding having therapy sessions recorded. The service users are in a vulnerable situation and the impact of being recorded could affect the original interaction. Speer and Hutchby, (2003) suggested participants' awareness of the recording of their behaviour distorts that very behaviour, thus contaminating the research object. However, Hutchby (2001)

explored how recording equipment in a counselling session was utilised by both the counsellor and service user to facilitate talk about fears and concerns. Furthermore Hutchby *et al* (2012) found that in clinical settings such as therapy, the recording equipment was treated as at worst un-problematically present, and at best clinically valuable to those participating. In many cases service users viewed recording equipment as beneficial to themselves and others.

6.7. Transcription of the Data:

The extracts presented in the analysis were transcribed using full Jeffersonian notation (see appendix 5) which aims to compensate for the loss of paralinguistic features such volume, pace and so on within the interaction when converting sound into text (Puchta and Potter, 2004). Jeffersonian transcription is the most time-consuming format of transcription for verbal data; it can take up to 20 hours of transcription time per recorded hour because of all the add-ons in the text (Potter, 2004). As Jeffersonian transcription is time consuming, an initial pragmatic transcription of all the recordings of the CBT sessions was conducted. Pragmatic transcriptions are a verbatim (i.e. word for word) reproduction of what is said, but less elaborated than Jeffersonian transcripts. A pragmatic transcription will exclude things not needed for the initial analysis of the recordings (e.g. every instance of stuttering) and include aspects identified as relevant to the initial analysis (e.g. overlapping speech, silences/hesitations without timing them). Typically, pragmatic transcription will take between four to eight hours of transcription time per recorded hour, depending on audio quality, pronunciation and typing speed (Evers, 2007).

6.8. Conducting the Analysis:

An iterative approach to the analysis was taken. The aim was to identify defining features of therapeutic discourse and examine how depression and identity are portrayed and talked about. The analysis also aimed to establish how CBT strategies are implemented and attended to during therapeutic interactions. Together these aims provide a discursive examination of therapeutic interactions between service users and therapists during CBT sessions for depression.

Firstly, the transcripts of the CBT sessions were read and reread individually over an

eleven-month period (December 2015 – November 2016). To begin with, the corpus was searched and coded, to identify common features, strategies, or repertoires. This thematic part of the analysis highlighted key features regarding the content of therapeutic talk/interactions, the construction of depression and the construction of the self during CBT. Examples of the features, strategies, or repertoires identified include:

- *Doing emotion:* This feature appeared in the majority of transcripts. It included the use of laughter, explicit language, raised voices and crying. Emotion was used by both the service user and therapist and was often used to elicit empathy, emphasise distress, attribute blame and trivialise what was said or to change topic.

- *Managing attributions for depression:* This strategy appeared in many of the transcripts. The service user and therapist drew on many reasons to account for depression, such as: life events, work, friends, family, childhood, watching soaps, money, bereavement, failings, genes, chemical makeup, making mistakes, thinking too much, the brain, drink and drugs, fear and the unknown. This is a broad theme but elements of this can be seen in how service users and therapists construct depression (chapters eight and nine) and construct the self through a depressed lens (chapter ten).

- *The absence of the terms depressed and depression:* This strategy appeared in every transcript. In total the terms were utilised six times in sixteen hours. Instead service users utilised alternative terms to construct and orient to depression. The significance of this, and how depression is constructed and oriented to without naming it, is discussed in chapter eight. The deviant cases where the terms are utilised are discussed in chapter nine.

- *Physical symptoms:* This repertoire was prominent in discussions regarding the effects of depression. Service users often used this repertoire to: argue for the detrimental effects depression has on their quality of life, give depression ontological status and establish victim status. Physical symptoms included: colitis, headaches, body aching, muscles being tense, not sleeping, and feeling tired or drained.

- *Being normal:* This identity work is broad and was used in discussions regarding

comparison to others, being better than others, needing reassurance that they are normal, asking if how they are feeling is ok or unusual, and stating how they would normally behave to demonstrate change. This feature can be seen in chapter ten in constructions of the self through a depressed lens. It was often utilised to gain reassurance or demonstrate that a change has taken place due to depression.

- *Being mad and insane:* This identity work was seen in two ways. Firstly, the self was occasionally constructed as mad or insane to position the self as inherently flawed and beyond help. Secondly, service users often described others as mad or insane for misunderstanding them and treating them unfairly because of depression. Elements of this theme can be seen in chapter eight where the service user positions them self as misunderstood and unduly stigmatised by others.

- *Identity and change:* This identity work was prominent in the corpus. There were numerous constructions of the self and references to a changed identity. The self was constructed as both positive and negative and was often used by service users to demonstrate vulnerability distress and account for depression. The notion of identity and a changed identity is seen in chapter ten.

- *Managing accountability through the construction of control:* This was a prominent strategy within the transcripts. The therapists often attempted to position service users as in control of their distress and recovery; whereas service users often constructed themselves as lacking control to diminish accountability for depression. This theme can be seen most notably in chapters one and two where the service user and therapist construct depression. In chapter eight extract one (B), it demonstrates how the therapist delicately shifts accountability for depression away from external triggers and onto the service user, positioning them as in control of their recovery.

- *Concealment and stigmatisation:* This repertoire relates to characteristics associated with mental health and media depictions that suggest individuals with mental health should be avoided due to unpredictability or dangerousness. Service users reported stigmatisation from others and a fear of stigmatisation from others. This resulted in service users concealing their depression from

friends, family and work colleagues. This feature can be seen in chapter ten, extract three - the self through a depressed lens.

- *Progress and recovery:* This feature noted positive remarks to change and progress. The service user and therapist often highlighted areas of improvement and change and referred to a 'switch in mind set'. This theme often occurred in the latter stages on therapy and was used to demonstrate improvement and construct happiness.

- *Therapeutic relationship:* This feature included elements of talk that signalled alignment or misalignment between the service user and therapist. It highlighted specific word usage that signalled alignment and highlighted ways that the service user argued against the therapist's formulations. This theme is seen within chapter seven which explores how therapists implement cognitive behavioural strategies and how service users attend to them. It also explores therapeutic interactions in more detail.

- *Not doing homework:* This strategy occurred in numerous transcripts. Beckworth and Crichton (2014) discussed how homework is a point of contention in CBT because it poses an imposition on the service user and often involves discussing emotive subjects. In the current corpus many excuses were given for not completing homework. These included: I didn't get much from it, I didn't do the homework, I lost my phone, I'm not worthy of homework, and homework is too indulgent I see it as a treat. The sometimes troubled implementation of CBT strategies is reflected in chapter seven's analysis of cognitive behavioural strategy implementation.

Once the initial features were identified, the transcripts were analysed to identify what the service users and therapists' dialogue is used to accomplish within therapeutic interactions; to create an understanding of what each extract is doing. To accomplish this, consideration was given to variation (Potter and Wetherell, 1987), ideological dilemmas (Billig *et al* 1988) and interpretative repertoires (Potter and Wetherell, 1987). These are explained below.

Individuals' accounts will vary according to the function of the talk (Potter and Wetherell, 1987: 33). Considering the contradictions and diversity within the dialogue

can enable the identification of the action orientation of the talk (i.e. what that speaker is attempting to accomplish with their talk). An ideological dilemma is a specific type of variation that occurs in talk. Ideological dilemmas occur when individuals attempt to manage competing common sense ideas. These ideas are reconstructed as contradictory themes/ statements that subsequently create discussion, argumentation and dilemma (Billig *et al* 1988: 6). One example of how ideological dilemmas are managed is through disclaimers (Hewitt and Stokes, 1975). Disclaimers allow the speaker to ward off potential interpretations of what the speaker is about to say (Billig *et al* 1988). An example of an ideological dilemma within the current analysis was regarding accountability for depression. Whereby depression was either constructed as attributed to the service user or external events/triggers. The therapist managed the ideological dilemma of accountability by presenting the service user as accountable for their reaction to negative life events but not accountable for the events happening.

Interpretative repertoires can be defined as a lexicon of terms and metaphors that speakers draw on to conceptualise or appraise actions and events (Potter and Wetherell, 1987: 128). They are often referred to as linguistic resources or "the building blocks of conversation". A range of linguistic resources can be drawn on during interaction (Edley, 2001: 198). Chapter four demonstrated how a number of interpretive repertoires are drawn on when constructing depression and individuals with a diagnosis of depression. One example was that professionals constructed depression as true depression when it was the result of a biological deficiency. This separated individuals into different groups or subject positions; genuine depressed individuals and bogus depressed individuals. This had implications for treatment choice, legitimacy status and the construction of individuals as severely ill. Identifying discursive features can provide an understanding of the way something is constructed. It can demonstrate how a range of linguistic resources can draw on the same rhetorical strategy to accomplish the same action orientation. This is particularly apt in chapter eight.

However, solely identifying instances of action orientation through variation, ideological dilemmas and interpretative repertoires do not constitute an analysis. At present there is no definitive universal way of conducting discourse analysis (Potter and Wetherell, 1987). The current data analysis is in line with Potter and Wetherell's (1987) model of discourse analysis. The current analysis will focus on what is being constructed within the extract, what these constructions are being used to accomplish and how they are attended to.

The chapters developed when a number of related or opposing strategies were identified. They emerged when the themes listed above were scrutinised for action orientation. For example the theme *reasons for depression* depicted depression as the result of various factors, one such factor was negative life events. This theme developed an understanding of the significance of how depression is conceptualised (e.g. negative life events constructed depression as the result of external factors and not occurring without reason). The analysis then focused more thoroughly on the ways depression is conceptualised and the actions these conceptualisations accomplished (e.g. this strategy enabled the service user to justify their distress and position themselves as unaccountable for depression). The extracts were then grouped together with utterances accomplishing the same discursive action. This helped form the sections of analysis. Each section contains extracts that utilise the same utterances to accomplish a particular discursive action. The final selection of extracts, were chosen because they are both indicative and representative of the rhetorical strategy being illustrated. Therefore, the discursive featuresidentified in this analysis are illustrative of wider patterns within the data. There are exceptions to this, for example chapter nine examines the rare, extreme or deviant cases. One extract is presented to demonstrate each strategy to allow for a detailed and thorough analysis. The extracts were chosen because they best demonstrate the discursive feature being presented.

6.9. Participants' Orientations:

The argument surrounding participants' orientations is longstanding and complex. The following section provides a brief overview of the key arguments from both sides of the debate. It then goes on to state where this project sits within this argument. For a more detailed description of the argument see Schegloff (1997; 1999) and Wetherell, (1998).

DP has been criticised by conversation analysts, particularly Schegloff (e.g 1997) for being influenced by researchers' existing assumptions. CA claims that analysis should only focus on what the speaker makes relevant. From this perspective "depression" is only relevant in therapeutic interaction if the speaker can be seen to orient to its relevance. Depression should not be assumed to be an issue (Schegloff, 1997). However, DP consists of detailed analysis of the action orientation of talk (derived from conversation analysis) and an interest in discourse, power and subjectification (derived from a post-structuralist, Foucauldian theory) (Wetherell, 1998). Therefore one of the aims of discursive analyses is to show non-obvious ways in which language is involved

in constructing psychological phenomena (Edwards, 1997). DP also suggests analysis must begin by studying participants' concerns because the act of choosing one particular text over another is already deciding what is relevant to the speaker (Wetherell, 1998). The debate regarding participants orientations has occurred to ensure discursive research is 'bound to the data', and does not risk becoming merely ideological. Moreover analysis must capture at least in part, the demonstrable original significance of the dialogue.

The setting of the interactional talk (CBT) and the PHQ-9 scores (measuring depression symptomology) mean that depression is salient and contextually relevant to the interaction in the data. This supports Wetherell's position that certain concepts may be relevant in some interactions regardless of whether they are directly oriented to by the speaker. This is because the dialogue in the current analysis would not have occurred had depression not been an issue, which the service user was seeking help for through CBT. Although depression is deemed to be already relevant, the current thesis aligns with Schegloff's claims/argument whereby in order to ensure the analysis 'binds to the data' and does not risk becoming 'merely ideological', depression can only be made relevant when the speaker can be seen to orient to its relevance (Schegloff, 1997: 183). The current thesis takes this notion further and suggests that service users and therapists can orient to depression (making it relevant) without explicitly naming depression in their dialogue. Therefore overall, the automatic relevance of depression cannot be ignored due to the interactional setting and purpose of the interactional dialogue. But the construction of depression can only be analysed when it is made relevant to the analysis by the service user and therapist.

This position is similar to Edley and Wetherell's (1997) approach that draws on both the top-down and bottom-up approach to discourse. The top-down approach focuses on issues of ideology and matters outside of the text, which is argued for by FDA (Shapiro 1984). A bottom-up approach focuses on the action orientations located within a text, which is argued for by Schegloff (1999) and Speer (2001). Taking a middle ground approach would enable the benefits from the detailed analysis associated with discursive psychology and conversation analysis. However, this position is not able to simultaneously look beyond the text while staying within it (Billig, 1999; Wetherell, 1998).Therefore the position taken in this analysis diverges from Schegloff's claim that depression would need to be directly oriented to by participants and aligns with Wetherell's (1998) position. This is because it has been demonstrated that depression is

already relevant given the specific conversational setting and that the interaction would not have occurred had depression not been an issue, which the service user was seeking help for through CBT.

6.10. The Generalisablity of the Findings:

Discursive psychology does not aim to test hypotheses that can be generalised to a whole population nor does it aim to predict the actions of individuals or groups. The analysis can however claim that certain strategies accomplish certain interactional achievements and that a certain strategy will often accomplish the same action in a variety of interactions (Goodman, 2008). Therefore it can be argued that a discursive strategy identified within the analysis can be generalisable to the extent that the 'action' that it accomplishes can be generalised across contexts (Goodman, 2008). However, the dialogue in this research is from a specific context (CBT sessions) and from a specific sample (trainee therapists and predominantly female service users). Therefore the findings of this thesis can be considered generalisable within CBT therapeutic interactions or more broadly generalisable to discussions about depression. However the findings cannot be generalised across therapeutic disciplines, non-trainee therapists and service users from non-western cultures. Furthermore, the discursive features identified in this analysis are illustrative of wider patterns within the data. The extracts were chosen because they best illustrated regularly occurring rhetorical strategies. This enables claims that certain strategies accomplish certain interactional achievements. An example of this is the construction of depression as a consequence of negative life events. This was used to position depression as something that does not occur without a trigger. While not every occurrence of this strategy is included in the analysis, it can be argued that this strategy will always function to present depression as something that does not occur without a trigger. While the analysis cannot claim to generalise these findings to the extent that it could predict exactly who would use such a strategy or when, it can however postulate that such a strategy would most likely be employed by individuals with depression who are managing their accountability for depression. Such a strategy would probably be used during an interaction when it would be rhetorically useful to highlight how their emotional distress is a justifiable reaction to external triggers, and out of their control. However, some extracts were chosen because they represent deviant cases and are not representative of wider patterns within the data.

When this was the case it is clearly stated that the extracts are examples of deviant cases to ensure transparency.

6.11. Summary:

The aim of the thesis is to discursively examine therapeutic interactions between service users and therapists during CBT sessions for depression. This chapter has argued that a discursive psychological approach, and its associated method discourse analysis, was the most appropriate to explore this aim. The aim of this thesis is accomplished via four analytical chapters. The first analytical chapter explores how therapists implement CBT strategies, how CBT gets done and how service users attended to therapeutic questioning. The second analysis examines how depression is constructed and talked about, in the absence of the terms "depressed" and "depression". Analysis three is a deviant case analysis conducted on the utilisation of these terms to explore how depression is constructed in CBT and what the terms are used to accomplish. Because identity work was a prominent finding in the transcripts, and an important issue within CBT, the final analytical chapter explores how the self and identities are constructed in CBT.

Chapter Seven – A Discursive Evaluation of Cognitive Behavioural Therapy Strategies:

7.1 Overview:

This chapter will explore how cognitive behavioural strategies are implemented and attended to within CBT sessions. It looks at how CBT strategies accomplish their therapeutic aim, troubled responses to CBT strategies and where the CBT strategies accomplish the therapeutic aim but neglect mediating factors that the service user highlighted as important. Therefore, this analysis is an assessment of CBT techniques in practice and an evaluation of how CBT gets done. This is a novel contribution because it is the first DP study of how therapeutic work is accomplished in practice, rather than how it should be accomplished as demonstrated in textbooks. This will aid clinical practice and highlight effective ways of communicating in therapeutic interaction to enable cohesion and therapeutic alliance. It also has wide implications for trainees because it can be used as a resource for how to accomplish therapeutic aim, how to overcome troubled responses and how CBT gets done in clinical practice.

7.2 Introduction:

7.2.1. Cognitive Behavioural Therapy (CBT):

The cognitive model of depression postulates that an individual's affect and behaviour are determined by the way an individual perceives and structures the world (their cognitions) (Weishaar and Beck, 1986). It is assumed that a change in cognition will induce changes in the symptomology of depression (Greenberger and Padesky, 1995). CBT is problem orientated and reliant on a process of questioning and guided discovery (Hawley *et al* 2016). Therefore, the goal of CBT is to help service users find solutions to their problems using cognitive-behavioural strategies (Hundt, *et al* 2013; Strunk *et al* 2014). The cognitive-behavioural strategies implemented by therapists in this analysis include behavioural analysis, identifying negative automatic thoughts (NATs), downward arrowing technique, cognitive behavioural formulation of depression and identifying issues most open to change. These will now be discussed in turn.

Behavioural analysis involves eliciting a detailed description of a recent example of the service user's problem. The description of the problem should include the internal

events, such as thoughts, feelings and physical symptoms as well as overt behaviours and the precipitating event (Hawton *et al* 1999). The therapist's goal or therapeutic aim is to elicit specific details, rather than generalities, to build a picture of the problem and how distressing and disruptive it is for the service user (Hawton *et al* 1999).

Identifying negative automatic thoughts (NATs) involves eliciting a detailed description of unpleasant emotions (because this signals the presence of NATs), the situation in which these occur (i.e. what the service user was doing or thinking when the emotion occurred) and a description of the NATs (what went through the service user's mind and the degree to which they believe the thought) (Hawton *et al* 1999). Most CBT sessions are dedicated towards teaching service users to identify, question and test NATs because this is postulated to reduce depressive symptomology. Therefore, the therapist's goal or therapeutic aim is to elicit a description of the emotions, the situation and the thought.

A cognitive formulation of depression provides a cognitive behavioural explanation for depression and the service user's distress. This is utilised to help the service user to understand depression and the CBT perspective. It also positions the service user as in control of their distress and recovery.

Downward arrowing is utilised to identify dysfunctional assumptions. This strategy involves identifying the problem situation, emotions and negative thoughts, but instead of challenging the thoughts, the therapist asks questions regarding the meaning of the thought. This process is repeated until a general statement is generated that can be challenged. Therefore, the therapist's goal or therapeutic aim is to generate a description of what the negative thoughts mean to the service user in order to acquire a general statement that can be challenged by the service user.

Identifying issues most open to change is utilised to determine what CBT strategy to use and when. The therapist's goal or therapeutic aim is to work with the service user to establish what problem is most open to change and determine their next target for intervention.

The current analysis aims to discursively evaluative therapeutic interactions during CBT to provide an understanding of how these cognitive behavioural strategies are implemented and attended to, and their discursive effectiveness. The aim of the analysis

is not to state whether these CBT strategies are effective in terms of outcome or whether they reduce depression. Instead, when evaluating the effectiveness of CBT strategies, it will be referring to the discursive effectiveness of the CBT strategies. For example, whether the strategies elicit the preferred response; encourage dialogue; alignment; troubled responses (where there is a lack of alignment); and whether the pursuit of the therapeutic aim neglects the service user's concerns. It will evaluate the extent to which the CBT process gets done (i.e. whether the therapeutic aim is accomplished).

7.2.2. The Cognitive Therapy Scale –Revised (CTS-r):

Currently, the adherence to the therapy method and the skill of the therapist are assessed via the Cognitive Therapy Scale –Revised (CTS-r). The CTS-r comprises of twelve items[4] rated on a seven-point scale; extending from (0) the therapist did not adhere to aspects of therapy, to (6) there is adherence and very high skill (see appendix 7). The CTS-r reduces therapeutic dialogue to a numerical value and directs the focus away from interaction (Potter, 1998). In contrast, the central theoretical underpinning of discursive psychology is anti-cognitivist. That is, it studies talk, examining the discursive practices and the resources speakers draw on rather than making realist claims about what people really think or how their thought processes have changed (Edwards, 1997; McKinlay, 1988). To date, no research has discursively analysed how items assessed via the CTS-r are constructed in talk. Most items on the CTS-r evaluate cognitive behavioural strategy implementation. However, Item Five – Interpersonal Effectiveness, suggests that the service user should feel that warmth, genuineness, empathy and understanding are present. It does not however state how these notions should be accomplished. Therefore, in addition to examining cognitive behavioural strategy implementation the analysis will also examine how warmth, genuineness, empathy and understanding are constructed in therapeutic dialogue whilst still accomplishing the CBT therapeutic aim (Potter, 1998).

[4] The twelve items assessed via the CTS-r include: Agenda setting and adherence; feedback; collaboration; pacing and efficient use of time; interpersonal effectiveness; eliciting of appropriate emotional expression; eliciting key cognitions; eliciting and planning behaviours; guided discovery; conceptual integration; application of change methods; homework setting.

7.2.3. Overview of Previous Literature:

Although studies have discursively examined therapeutic interactions, there has not been a strong focus on CBT. To date discourse analytic research regarding therapeutic interactions has largely focused on systemic and psychodynamic therapy (Roberts, 2015). Finlay and Robertson (1990) explored the use of 'quasi-direct discourse' in psychodynamic therapy (i.e. utterances that lie 'between' direct discourse; uttering one's own words and indirect discourse; quoting the talk of another. This form of talk functions to demonstrate active listening, maintain neutrality, attribute meaning to the service user's dialogue and express thoughts and emotions on behalf of the service user (Finlay and Robertson, 1990). In addition to this, Ferrara (1992) and Lewis (1995) both examined the therapists' *conversational style* in psychodynamic psychotherapy. They highlighted how the therapist gradually adopted the service user's conversational style to create joint-productions. This style was used to create empathy, conversational involvement and coherence. Couture (2007) and Kogan and Gale (1997) examined how a creating a multi- authored narrative was utilised to accomplish forward movement after conversational impasses.

Other studies focus on the therapeutic relationship. Roy-Chowdhury (2006) reviewed systemic therapy sessions and highlighted that a good therapeutic relationship consisted of higher levels of participation, consensus, minimal acknowledgments and mirrored lexical choices. A weak therapeutic relationship was characterised by low engagement and consensus, different lexical choices and dispreferred responses or not answering the question. Others have examined resistance in therapy (Van-Denburg and Kiessler, 2002). Resistance was found to be displayed through several linguistic features such as: low levels of speech activity, increased pauses, fewer acknowledgement tokens, increased first person pronoun use, high use of the passive voice and increased instances of interrupting and overlapping (Grabhorn *et al,* 2005).

The majority of discursive CBT literature focuses on service users' experiences of CBT and examines this via a discourse analysis of interview transcripts (Beattie *et al.* 2009; Messari and Hallam, 2003). Only two studies have discursively examined therapeutic interactions during CBT, one focusing on metaphor use (Mathieson *et al* 2016), and another on homework implementation (Beckworth and Crichton, 2014). Therefore, this is the first analysis to discursively evaluate therapeutic interactions during CBT, to provide an understanding of how cognitive behavioural strategies are implemented and attended to, and their discursive effectiveness.

7.2.4. Research Aims:

To date no discursive research has focused on therapeutic interactions and the implementation of CBT strategies, nor have they discursively analysed how items assessed via the CTS-r are constructed in talk. The current analysis aims to discursively evaluate therapeutic interactions during CBT, to provide an understanding of how cognitive behavioural strategies are implemented and attended to, and their discursive effectiveness. For example, whether the strategies induce the preferred response, encourage dialogue, alignment, troubled responses and by evaluating the extent to which the CBT process gets done. This analysis will aid clinical practice, add to the limited discursive research regarding CBT and provide an insight into how items on the CTS-r are constructed in talk during therapeutic interactions between service users and therapists.

7.3 Analysis:

7.3.1. Overview of Key Findings:

Effective implementation of the CBT strategies was characterised by four discursive features: (1) accomplishing the therapeutic aim by successfully eliciting descriptions of the service users' problems, (2) attending to what the service user highlighted as important; eliciting talk about emotion, (3) Composing questions gradually and (4) creating a joint narrative to infer empathy. Ineffective implementation of the CBT strategies was characterised by: (1) not accomplishing the therapeutic aim, (2) dispreferred responses, (3) limited elicitation of dialogue, (4) misalignment, (5) troubled responses, demonstrated through resistance or short answers and (6) questions that were presented as closed. The final finding was that the therapist accomplishes the therapeutic aim but neglects other mediating factors such as hopelessness and distress. When doing this therapists' questions were short, direct and closed.

7.3.2. Therapeutic Alignment and Accomplishing the Therapeutic aim:

The first section of analysis demonstrates how the cognitive behavioural strategies, behavioural analysis and identifying NATs, are implemented effectively in terms of inducing the preferred response; therapeutic alignment; and eliciting dialogue about an

issue. It is also effective in terms of Item Five on the CTS-r because the therapist attends to the service user's responses and demonstrates empathy and understanding. This section of analysis demonstrates how the CBT process gets done i.e. how the therapist accomplishes the therapeutic aim associated with the cognitive behavioural strategy.

Extract one demonstrates the implementation of the CBT strategy, behavioural analysis. The therapeutic aim is achieved here as the service user provides a description of their internal events such as thoughts, feelings and physical symptoms and overt behaviours. In addition to this the therapist also attends to the service user's elicitation of emotion and distress. Therefore, extract one is used as an example of how the CBT process gets done. The first extract is an exchange between a service user and a therapist during their third therapy session. In the dialogue prior to this extract, the service user and therapist identified "lack of motivation" and "socialising" as problems the service user wanted to explore in the therapy session.

Extract One - Service User SUB and Therapist T02:

1	**Therapist:**	ok: (.) so↑ the thoughts: that went through your mind: (.)
2		before you went were (.) there's↑ no point (.) I'll be in a
3		rubbish mood↓ (.) nothing: excites: me: (2.50) and then
4		(4.02) how are you feeling: (2.03) how↑ would you say °you
5		were feeling:° (2.07)
6	**Service User:**	I felt (.hhh) down: un (3.07) ((*starts to cry*)) I don't know:
7	**Therapist:**	anything else with that (2.07)
8	**Service User:**	((*starts to cry*)) I was I was like like nothing excites me (.)
9		like what's the point: ((*cries*))
10	**Therapist:**	I know: ((*comforting mumble*)) (7.37) so it (.) would you
11		say:: (.) that it's↑ (.) when you feel that: (.) you should be
12		enjoying what you're doing:: and then you find↑
13	**Service User:**	((*Cries*)) <I have no reason not to>
14	**Therapist:**	yeah:
15	**Service User:**	like all of my friends are ((*cries*)) going: off and seeing all of
16		them
17	**Therapist:**	yeah:
18	**Service User:**	You know↑ it's the weekend↑ n ((*cries*)) umm n I've got my
19		boyfriend there:: (.) (.hhh)

Therapist: would you say that it's the thought of going out: (.) that triggers you to feel low(.) or: is it when you're already feeling low that the thought of going out (.) makes you feel worse↓which of those two

Service User: ((*cries*)) <yeah the first one> (.) the thought of going out

Therapist: The thought of going out↑ (.)

Service User: Yeah (5.05)

Therapist: Ok: (.) so it seems like (.) as soon as↑ you think about going out then that's↓ (..)

Service User: I'm like: I can't be bothered::

Therapist: These things go through your mind: (.) and then↑ (..) that's sort of feeding: into your feeling: though: (.)

Service User: It's just not like me↑ at all::

Therapist: Yeah I know::

Service User: I used to love:: seeing my friends:: (.)

Therapist: how do you think (.) was there anything that you noticed in your: (.) any body sensations that you noticed before you went out:↑

Service User: umm (2.07) I was just like really tired: and umm: (4.03)

Therapist: Uh

Service User: couldn't be bothered to do anything: (1.50)

Therapist: so:

Service User: like not even like cooking dinner↓ (.) like even my boyfriend cooked the dinner↓ (h) and he was at my house

Therapist: Maybe:: a bit lethargic::

Service User: Sort of

Therapist: Yeah

Service User: I just couldn't be bothered:: to do anything: ((*cries*))

Therapist: ok↓ (.) an then so (.) what did you do (.) you said (.) behavior wise you↑ (.) asked your boyfriend↑ to cook dinner↑

Service User: Mmm (6.07)

52 53 54	**Therapist:**	And how about↑ (.) getting ready for going out↑ (.) did you do what you would normally:↑ do:: (.) to get ready to go out::↑
55 56	**Service User:**	Umm (.) well I had to rush cause I'd taken so much time like dwelling on it
57	**Therapist:**	Deciding whether to go or not: (h)
58	**Service User:**	Yeah::

Extract one demonstrates the implementation of *behavioural analysis.* Here the therapeutic aim is to acquire a description of the service user's current problem. *Behaviour analysis* is accomplished by acquiring details regarding the internal events, thoughts, feelings and physical symptoms, as well as overt behaviours and the precipitating event. The implementation of this strategy is accomplished in four stages.

Firstly, the therapist reformulates the service user's dialogue regarding their "thoughts", via indirect discourse (line 1-4) (Finlay and Robertson, 1990; Perakyla *et al* 2008). This is therapist initiated. It creates a multi-authored narrative, and demonstrates active listening. The therapist questions what the "thoughts" made the service user feel (line 4-5), to elicit details regarding "emotions", which is in line with the therapeutic aim. The questioning is composed in a two-part conditional structure, to situate the "thoughts" as having agency over the service user's affect (i.e. listing the thoughts and then asking about the feelings, line 1-5) (Sneijder and Te-Molder, 2005). The service user attends to this questioning with the preferred response by depicting how they felt (i.e. down, apathy and hopelessness) (line 6 and 8-9) (Pomerantz, 1984). In addition to eliciting a description of an emotional state (i.e. "I felt down"), the service user also elicits an emotional display (i.e. crying)(line 6 and 9). This functions to indicate and emphasise the severity of the low mood (Hepburn, 2004). The therapist attends to this via interjections to produce an expression of empathy ('I know', line 10) (Wharton, 2003).

After establishing details regarding the "emotions" associated with not wanting to go out, the therapist attempts to elicit details regarding whether the thought of going out triggers their low mood or if the low mood comes first and is exacerbated by the thought of going out (line 20-23). This questioning is composed via quasi-direct discourse to create joint authorship (line 20) (Finlay and Robertson, 1990). This also

softens the questioning. Presenting two options for the service user encourages forward movement of the dialogue to acquire a detailed description of the problem (line 20-23). The service user attends to this questioning by choosing one of the presented options (the thought of going out triggers the emotion, line 24).

Next the therapist attempts to elicit details regarding the "physical sensations" felt in the situation. This questioning contains two self-repairs (line 35-37), which softens the questioning making it less direct and abrupt (Levinson, 1983). The service user responds to this question hesitantly, demonstrated through interjections and minimisations (line 38) (Wharton, 2003). However, the therapeutic aim is accomplished as the service user depicts their physical sensations (feeling tired, line 38-40) and supports this with evidence (that she couldn't even be bothered to cook dinner, line 42-43). During this depiction, the therapist's responses are minimal and used to demonstrate listening and encourage forward movement (line 39 and 41).

In the final stage of implementing *behaviour analysis*, the therapist attempts to elicit details regarding "overt behaviours" during the event (what she did to get ready to go out). The gradual building of the question, from a broad question ("what did you do" line 48) to a specific question ("did you do what you would normally do" line 52-54), is used to obtain the preferred response, make the question easier to answer and put the service user at ease by coaching them into an answer (line 48-54) (Freesmith, 2007). The service user attends to this questioning with the preferred behavioural response; responding that her usual routine was not followed as they were rushed (line 55-56).

Overall the therapeutic aim to acquire a description of the service user's current problem can be considered accomplished. Furthermore, the therapist attends to what the service user highlights as important and the service user's display of emotion, creating empathetic responses that demonstrate understanding and active listening.

Extract two is another example of the effective implementation of a CBT strategy. Here the therapist is implementing the cognitive behavioural strategy identifying NATs. This is again therapist initiated. The therapeutic aim is achieved here as the service user identifies their emotions and NATs that occurred within a situation. Extract two is used here as another example of how the CBT process gets done. This is because in addition to accomplishing the therapeutic aim, the therapist promotes dialogue around the event, reformulates the service user's dialogue to display empathy, and attends to what

the service user highlights as important. These discursive accomplishments are deemed effective in terms of Item Five on the CTS-r. Extract two is an exchange between a service user and a therapist midway through their sixteenth therapy session. In the dialogue prior to this extract the service user and therapist discussed the service user's appraisal at work and how members of staff had been "nice" to the service user as part of the "bless your boss day". The service user identified others talking about them as a situation that was causing them distress in the form of "worry" and "stress".

Extract Two: Service user SUC-R2 and Therapist T03

1	**Therapist:**	So what what's your kind of initial thought about that what
2		what would be your kind of (.) initial automatic thought
3		negative positive neutral what kind of things popped up
4	**Service User:**	I think yeah:: it's probably not negative it's probably you
5		know↑ (.) they're trying to show me that they're (.) you
6		know↑ supporting me fully
7	**Therapist:**	°Yeah::° ok
8	**Service User:**	Which is obviously nice (h)
9	**Therapist:**	Which is really nice: (.) is there any negativity there at all:
10		is ur I'm just wondering what's kind of upsetting you (.) do
11		you believe them↑ I guess is the question do you believe↑
12	**Service User:**	Umm (3.50) yeah:↑ I think so (h)
13	**Therapist:**	That's good::
14	**Service User:**	Yeah (.) I think I think it was just because I was (.) yeah (.)
15		because I was emotional anyway
16	**Therapist:**	Yeah
17	**Service User:**	I just (.) couldn't cope with↓ you know: cause cause I felt
18		really low:: n I'm like I need to try n be happy↑ n respond↓
19	**Therapist:**	Yeah
20	**Service User:**	Because they're being nice to me and I can't:: (.) like I don't
21		feel like doing that right now:
22	**Therapist:**	I see:
23	**Service User:**	kind of thing
24	**Therapist:**	so it's quite quite hard to switch: off how you're feeling:↑

25 **Service User:** yeah

26 **Therapist:** n

27 **Service User:** pretend to be jolly when I didn't feel: it

28 **Therapist:** yeah: (.) but you it's nice to hear: you saying that what
29 they've done even though that's obviously what the theme:
30 of the day is: it's nice that they are really making an effort

31 **Service User:** yeah yeah

Here the therapeutic aim is to enable the service user to *identify their NAT*, the emotions felt, the situation in which the NAT occurs and the extent to which the service user believes the NAT. The therapeutic aim is accomplished through the therapist's questioning and eliciting details regarding the above areas of importance.

First the therapist asks the service user to identify their NAT (line 1-3). Similar to extract one, the therapist deploys their questioning delicately; gradually building from broad questions "what's your kind of initial thought" (line 1) to a specific question "negative positive neutral" (line 2-3) and then back to a broad question "what kind of things popped up" (line 3). This is used to obtain the preferred response, a description of the thought (line 4-6) and coach the service user into an answer (Pomerantz, 1984). The colloquial language "popped up" (line 3) provides a figuration of the NAT and creates a relaxed dialogue. The service user responds to the questioning with the preferred response ("it's probably not negative", line 4) and provides details regarding the automatic thought and how distressing it is (line 4-6). The service user's response is composed hesitantly via non-committal language "probably" (line 4) and invites confirmation from the therapist "you know" (line 4-5). This could be because the therapist's question was composed as requiring a certain response.

Next the therapist attempts to elicit information regarding "emotions felt" as these are postulated to signal the presence of NATs (lines 9-10). The therapist accomplishes this firstly by attending to the service user's previous statement and adopting the service user's conversation style ("which is really nice", line 9). This is used to demonstrate that the service user is being heard and understood (Lewis, 1995). The therapist then asks their question regarding "the emotions felt". Revealing personal motivation (I'm just wondering", line 10) allows the therapist to subtly build to the question and encourage forward movement where sensitive information might be disclosed (line 9-11).

The therapist then enquires about the strength of the automatic thought "they're trying to show me their supporting me" by asking whether the service user believes their colleagues' positive sentiments (line 10-11). Here the therapist is also still trying to identify a NAT that accompanied their negative affect ("what's kind of upsetting you" line 10). This questioning is composed gradually and hesitantly, via self-repairs and repetition, orienting to a need for delicacy (Levinson, 1983). The service user attends to the questioning with the preferred response, depicting their emotions and that they believe the NAT (line 12- 23). During this depiction, the therapist provides minimal responses that act as continuers and demonstrate empathy and understanding; "that's good" (line 13) and "I see" (line 22). The therapist also acknowledges the service user's concerns (being emotional) and attributes meaning to their dialogue (so it's hard to switch off) (line 24). This creates a joint narrative and demonstrates therapeutic alignment (Couture, 2007). In addition to this the therapist conveys encouragement and praise ("it's nice to hear you say" line 28) whilst reformulating the service user's dialogue into a summary (line 28-30) (Perakyla *et al* 2008). This adds therapist meaning to the service users dialogue in an attempt to convey a different perspective on events. By eliciting details regarding the service user's automatic thought and how distressing it is, the therapeutic aim of the questioning is achieved. In addition to this, the therapist attends to factors the service user highlights as important, offers encouragement, understanding and empathy. Therefore, extract two is an example of effective therapeutic interaction and good practice according to CBT guidelines.

7.3.2.1. Summary:

Extracts one and two demonstrate the implementation of the CBT strategy *behavioural analysis* and *identifying NATs*. Overall, the therapeutic aim can be considered accomplished as both therapists encouraged the service user to provide descriptions of their problems; NAT's, emotions, behaviours, situations and physical sensations. What is interesting about these extracts is how the therapist accomplishes the therapeutic aim. The therapist's questions are composed gradually and subtly, with indirect and quasi-direct discourse to create jointly constructed narrative and encourage dialogue. Furthermore, the therapists attend to what the service users highlight as important and their elicitation of emotion, which creates empathetic responses that demonstrate understanding and active listening, all of which are important accomplishments in terms of Item Five on the CTS-r.

7.3.3. Troubled Responses to Cognitive Behavioural Strategies:

The previous section of analysis examined how the CBT process gets done, the effective implementation of CBT strategies and how the therapist accomplishes the therapeutic aim. The proceeding extracts look at the implementation of the downward arrowing technique, cognitive behavioural formulation of depression and identifying issues most open to change. What is noteworthy about this section of analysis is how the cognitive behavioural strategies are met with troubled responses and are less effective in terms of inducing the preferred response; therapeutic alignment; and promoting dialogue about an issue. Therefore, the next three extracts are examples of how the CBT process does not accomplish the preferred goal.

Extract three is an example of a cognitive formulation of depression. The therapist constructs depression as "a consequence of negative perceptions" thus providing a cognitive behavioural explanation for depression and the service user's distress. This formulation is used to explain why the service user's symptomology has not dissipated and positions the service user as able to change or recover. Extract three is an example of troubled talk. The cognitive formulation of depression does not bring justification or relief to the service user. Instead it prompts the service user to argue against the therapist's formulation. This is accomplished by constructing depression as biological in origin and the result of their genetic makeup. The extract is an exchange between a service user and therapist at the end of their fifth therapy session. In the dialogue prior to this extract the service user was depicting concerns regarding relapse and constructed them self as "sliding down a slippery slope".

Extract Three – Service User SUD-R1 and Therapist T04:

1	**Therapist:**	I think I think you your only your gunna start sliding
2		down↓(.) if you do see it (.) you know these let's call them
3		failures: when they come along as being failures: (.) but if
4		you're perceiving them as something different↑ (.) then
5		you've got no reason: to slide back down that slide (.) yeah
6	**Service User:**	Mm
7	**Therapist:**	It's only that negative perception of things: (.) that's gunna
8		get you down there isn't it↑ (.) cause that's what it was
9		before:
10	**Service User:**	Mm (.) Yeah: yeah it is

Therapist: It's negative perception of things

Service User: Yeah it was yeah (.) you're right↓

Therapist: N you woke up the next day n you was like: yeah it's still shit

Service User: (h)

Therapist: (h) you know what I mean↑

Service User: Yeah:: I know what you mean:: (h) (.) gees (3.04) it's all a bit of ur:(.) catch twenty-two(.) cause I'm like:: scared of it

Therapist: Mm

Service User: But my being scared of it::

Therapist: Yeah

Service User: I'm trying: desperately: not to go: there↓

Therapist: Yeah

Service User: Is pushing me there↑ (..) a little bit↑ (.) it really feels like that like: (.) for the first time:: in several months::

Therapist: Mm

Service User: Yesterday when my mum:↑ (.) flew off the handle: (.) yesterday morning (.) I really did feel like:: (2.03) for a second (.) I got that

Therapist: Mm

Service User: That heart sinking: feeling↓ again of (.) how I felt a few months ago

Therapist: Mm

Service User: N it really doesn't feel good n I felt like that for quite a long time: when I was like (.) when I was a teenager:: n stuff n:

Therapist: Mm

Service User: When I like (1.53) legged it to Spain::

Therapist: Mm::

Service User: [5] umm (.hhh) (2.0) god: (.hhh) (.) n then I just start thinking >oh my god what's my life going to be like< am I (.) am I (.)

[5] The proceeding section of the extract was originally analysed in chapter eight

41		gunna be constantly in n out of <u>like:</u> this (.) >what is it
42		<u>depression</u>:< or I don't even know if (1.0) if its depression
43		(.) <u>depression</u>: <u>sound::</u> (.) <<u>really</u>: (.) full↑ on>
44	**Therapist:**	Yeah
45	**Service User:**	(.hhh) (2.0) Um (1.0) am I a <u>person</u>: ↑ who just
46		<u>programmed</u>: or (.) chemically: somehow my (.hhh) <u>make</u>
47		<u>up</u> (1.0) my (.) <u>genes</u>: or <u>whatever</u>↓
48	**Therapist:**	Mm
49	**Service User:**	Are::: (.) making (.) me always↑ on the edge of (.) <u>this:</u>
50		(1.0) <u>depression:</u> ↑ (.) thing (.) >that's going on↑< (.) how
51		can I get <u>rid</u> of that↑ (0.5) >can I get <u>rid</u> of that↑<

In line with the CBT model of depression the therapist constructs depression as a consequence of negative perceptions, by suggesting that changing perceptions will prevent relapse (" if your perceiving them as something different then you've got no reason to slide back down" line 1-12). This construction of depression was proposed in response to the service users previous dialogue in which they depict concerns of relapsing. This positions the service user as being in control of their distress and recovery. The therapist situates this explanation as the only explanation. This is accomplished by composing questioning explicitly as closed questions requiring a yes response (line 1-8) (Potter, 1996). Utilising the service user's previous experience as evidence to support their point ("cause that's what it was before" line 9-10) and adopting self-evident discourse ("it's only" line 7) (Potter, 1996). All of the above is used to depict the explanation as self-evident and make it hard for the service user to refute. Between lines 6-10 the service user offers signals of agreement, which is the preferred response ("yeah yeah it is"). The therapist attends to this by repeating their key argument; that it is negative perceptions causing depression and relapse (line 10). This time the notion that negative perceptions cause distress is presented as a statement rather than a question. This constructs the notion as factual (Freesmith, 2007). It also invites a stronger signal of agreement from the service user, seen on line 12 ("yeah your right"). Overall the cognitive formulation of depression situate the service user as in control of their distress and recovery, and therefore accountable for their depressed state.

After initially signalling agreement, the service user responds to the therapists cognitive formulation by positioning them self as lacking agency over their distress and recovery,

and argues against the notion that it is only negative perceptions causing distress and relapse. This is first accomplished by orienting to the possibility of relapse occurring ("I'm like scared of it" line 16-18). The service user then constructs them self as "trying" hard to not relapse (line 20). This positions the service user as lacking agency. Secondly the service user situates others as pushing them towards relapse ("pushing me there" line 24-25). Constructing others as causing the service user to relapse and invoking distress, is supported with an example of how their mother "flew of the handle" and caused them to feel distress (line 26-29). This anecdote is used as a counter claim to the therapist's formulation that it was "only their negative perception of things" that is causing them distress. Lastly stating that they felt like this as a "teenager" (line 35) constructs their distress as long standing and something they have always had. All of the above is used to argue against the notion that it is only negative perceptions causing distress and that they have control over recovery. Therefore, compared to the beginning of the extract, this is an example of a troubled response because there is a misalignment between the service user and therapist regarding relapse and depression. This can be viewed as dilemmatic talk because both the service user and therapist are providing common sense ways of understanding depression but also contradictory representations of depression.

At the end of the extract the service user goes on to argue more explicitly against the therapist's formulation of depression by constructing depression as biological in origin and the result of their genetic makeup, rather than a reaction or emotion (39-51). This constructs depression as a fixed experience with little prospect of resolution (Harvey, 2012). A detailed analysis of lines 39-51 can be found in chapter nine. All of the above positions the service user as lacking agency. This works to resist the therapist's formulation, that the service user's distress is only the result of negative perceptions and that they have agency over their distress and recovery.

Extract four is another example of how the CBT process does not accomplish the preferred goal and an example of troubled talk. The extract is an example of the implementation of downward arrowing. This extract contains an example of troubled talk as the service user resists the therapist's questioning and provides a dispreferred response. Furthermore, the downward arrowing strategy in this extract does not promote dialogue or elicit meaning. Extract four is an exchange between a service user and a therapist during their third therapy session. In the dialogue prior to this extract

the service user discussed not wanting to meet friends and not wanting to disclose depression to others.

Extract Four - Service User SUB and Therapist T02:

1	**Therapist:**	So: if say: it's one of your: friends↓ (.) that's feeling:↓ (.)
2		that felt: down and they told you I (.) >same sort of thing<
3		uh: I go out an um (.) <it all feels fake to me> and I'm: (.)
4		putting on a brave face:↑ (.) but I actually feel (.)
5		completely: rubbish↓ (.) what meaning:↑ would you: put
6		with that (.) <if↑ (.) they: said that to you:↑>
7	**Service User:**	I would say (.) that they were depressed↓
8	**Therapist:**	And does: that hold any meaning:↑ (.) if someone has:↓
9		depression (.) does: that: say anything about them as a
10		person:: or↑
11	**Service User:**	No: just they're not happy with (.) life:↓ at the moment:↓
12	**Therapist:**	Yeah so you (.) you don't (.) if it was somebody else you
13		wouldn't
14	**Service User:**	No I wouldn't no

In extract four the therapist is implementing the CBT strategy *downward arrowing*. The aim of *which* is to identify core beliefs/schemas by acquiring a general statement that can be challenged. The therapeutic aim is therefore to elicit details regarding the thought and what this means to the service user. The implementation of this strategy is accomplished in two stages.

Firstly, in response to the service user's prior dialogue regarding not wanting to meet friends and or disclose depression to others, the therapist reformulates the service user's previous statements regarding their distress and composed it in the third person from the perspective of the service user's friend ("if say it's one of your friends" line 1) (Perakyla *et al* 2008). This quasi-direct discourse does active listening and allows the therapist to express thoughts on behalf of the service user (Finlay and Roberts, 1990). The therapist orients to a need for delicacy via the use of self-repairs and false starts (lines 1,2,3) (Pomerantz, 1984). The repetitive pronoun selection "you" (line 5-6) directs the discourse towards the service user and posses the dialogue as a question that requires a response (Potter, 1996). All of the above is used to gradually and

tentatively build to the therapeutic aim; asking what the described emotional distress means (line 5) to acquire a general statement that can be challenged. The therapist's questioning (line 1-6), is initially met with the preferred response ("I would say they were depressed" line 7). However, the service user constructs this hesitantly and accounts for the possibility that they might not be giving the preferred response. This is accomplished by composing their disclosure as their opinion ("I would say" line 7) (Potter, 1996). Therefore, the therapeutic aim of eliciting meaning might not have been accomplished. Instead the therapist may have elicited the preferred response, i.e. what the service user thought the therapist wanted them to say.

The therapist does not attend to this possibility and instead attends to the service user's response as an elicitation of meaning, and probes for more information ("does that say anything about them as a person" line 8-10). This is constructed tentatively in a three-part list (Jefferson, 1990). This gradual building to the question is used to encourage dialogue from the service user. However, on line 9 the therapist utilises the term "depression" rather than the term used by the service user; "depressed" (line 7). This subtle lexicogrammatical preference as shown in chapter nine has an impact on aetiology, prognosis, trajectory and identity, and demonstrates a misalignment between the service user and therapist. This prompts the service user to explicitly reject the therapist's questioning and reformulate "being depressed" as unhappiness and a non-pathological transient state (line 11) (Harvey, 2012). Here *downward arrowing* does not promote dialogue; instead it reduces dialogue as demonstrated by the service user's short answers between lines 11 and 14. This extract also contains an example of troubled talk because of the misalignment, rejection of the therapist's insinuations and the service user's short responses. Therefore, the therapeutic aim of eliciting a description of the meaning of a thought that can then be challenged is not accomplished here.

A third example of troubled responses to cognitive behavioural strategies is demonstrated in extract five. Here the therapist is implementing the CBT strategy *Identifying issues most open to change.* The therapist's agenda is not accomplished because the service user resists the therapist's questioning and argues against change as a possibility, making it hard to establish what problem is open to change. Therefore, this extract is used an example of troubled talk. Extract five is an exchange between a service user and a therapist during their second therapy session. In the dialogue prior to this extract the service user discussed having trouble socialising, lacking confidence,

how they feel like a bad parent and their divorce. They also depicted a loss of inner peace and distress (see chapter ten extract four).

Extract Five - SUER1 and Therapist T04:

1	**Therapist:**	Mm (2.03) ok (1.50) so wh what is the easiest thing you
2		can change on there↓
3	**Service User:**	I guess my thoughts: I know I can change: my thoughts it's
4		just changing them
5	**Therapist:**	Are they↑ the easiest thing↑
6	**Service User:**	Well: yeah: I guess:↑ cause I can't change my behaviour if I
7		keep (1.47) thinking I'm a failure:
8	**Therapist:**	Mm
9	**Service User:**	Or thinking: that I'm a mug
10	**Therapist:**	Look at your behaviours on this side as well↑
11	**Service User:**	I can't change that physical stuff at the moment↓ (.) I just
12		can't↓(.) that's just
13	**Therapist:**	Ok
14	**Service User:**	N n n I just can't (.) >like if I don't go to the gym every day<
15	**Therapist:**	Mm:
16	**Service User:**	I just have too much (.) energy in me n too many thoughts
17		in me so
18	**Therapist:**	Gym gyms good
19	**Service User:**	Yeah::

Here the therapist is attempting to elicit information regarding what problem is most open to change and establish their next target for intervention. This action is therapist initiated. The therapist's questioning regarding what can be changed (line 1-2), is stated more explicitly here compared to extracts one, two and four; where the therapist gradually builds to the question. The service user responds to the question with the preferred response; in terms of therapeutic aim by suggesting "thoughts" are the easiest notions to modify (line 3-4). However, the therapist questions the service user's response (line 5), which orients to it being a dispreferred response (Pomerantz, 1984).

This is met with a more confrontational response from the service user ("I can't change my behaviour" line 6-7), whereby they situate their answer as correct and justify it with an explanation as to why they could not change their behaviour (line 6-7). The service user also emphasises the impact the "thoughts" are having on their ability to change other aspects. This depicts the thoughts as the most important aspect, and needing to be changed first (lines 6-7).

The therapist does not attend to the service user's argument and instead responds by asking about behaviours, another example of cognitive strategy implementation (line 10). This is met with more resistance from the service user ("I can't", "I just can't", 11-17). The service user justifies their argument against the therapist's suggestion of changing behaviours. This is accomplished by providing reasons why they cannot do what is being asked of them (line 11- 17). The service user also emphasises the importance of the behaviours and the positive benefits the behaviours (going to the gym) have on their wellbeing (line 11-17). All of the above is used to resist the therapist's suggestion that their behaviours should be changed before thoughts. The therapist concedes that the service user's behaviours might be beneficial via a signal of agreement (line 18).

The therapeutic aim to collaboratively establish what problem is open to change and most appropriate to target for intervention is not achieved in this extract. This extract demonstrates troubled talk because the therapist's questions are met with resistance from the service user. Although a key component of CBT is to challenge the service users constructions, the challenge does not appear effective in this extract because the therapist does not attend to what the service user highlights as important and argues against the service user's identification of what problem is the most open to change. Therefore both the service user and therapist resist each other's constructions, and thus demonstrate troubled talk. Troubled talk occurred here because the therapist's questions required a certain response; when the desired response was not given it created misalignment between the therapist and service user.

7.3.3.1. Summary:

Overall extracts three, four, and five contain examples where CBT process does not accomplish the preferred goal. The therapeutic aim is not accomplished because: the CBT strategy does not generate the preferred response, there is evidence of therapeutic

misalignment and the CBT strategy does not promote dialogue about an issue and in some cases dialogue dissipates. These extracts show how the service user attends to the therapist's implementation of the CBT strategy. The cognitive behavioural strategies are attended to with troubled responses. In extracts three and five the service user resists the therapist's assertion and argues against it. In extract four the service user responds with short answers that attempt to stop the therapists questioning. Furthermore, the therapist's questions are composed differently to extracts one and two where the questions are open ended. Here the therapist's questions are composed as closed questions requiring a certain response. Moreover, when the desired response is not given, it creates misalignment between the therapist and service user.

7.3.4. Accomplishing the Therapeutic aim but Neglecting Other Mediating Factors:

The previous two sections of analysis focused on "effective" implementation of CBT strategies and troubled responses to CBT strategies. The final section of analysis focuses on how, in the pursuit of the therapeutic aim, the therapist neglects mediating factors the service user highlights as important. The cognitive behavioural strategies implemented in extracts six and seven are deemed effective in terms of the therapeutic aim. However, what is surprising in this section of analysis is how the therapist achieves the therapeutic aim but their dialogue does not attend to the service user's responses and lacks empathy and understanding, which makes up the criteria specified in Item Five on the CTS-r.

Extract six is an example of the implementation of the CBT strategy behavioural analysis. Here the therapist's therapeutic aim is achieved as the service user constructs their thoughts, feelings and behaviours of the event. However, the focus on the therapeutic aim ignores the service user's display of hopelessness and despair. Extract six is also analysed in chapter ten, as an example of how the service user constructs their identity and positions them self as blameworthy for depression. Here it is used as an example of how the therapist accomplishes the therapeutic aim but neglects other mediating factors. Therefore the therapist does not construct factors deemed important on Item Five on the CTS-r. Extract six is an exchange between a service user and therapist taken from the first fifteen minutes of their fifth therapy session. In the dialogue prior to this extract the service user and therapist discussed the

service user's negative thoughts regarding missing a session and attending a music concert with their partner.

Extract Six: Service User SUF-R1 and Therapist T04:

1	**Therapist:**	N what was you thinking (.) what was your thoughts↑
2 3 4 5 6 7	**Service User:**	Umm (2.43) that if I (.) couldn't even enjoy one thing that I would normally enjoy↑ (1.40) then↓ (.) it's such: it's such a simple thing (.) that↓ (.) if that even can't be changed: then: >what is the point in even trying you know↑ n I'm pretty sure [*therapist*] doesn't like me as well because he thinks I'm attention seeking< (.) and all of this weird stuff:: (h)
8 9	**Therapist:**	(h) ok:: (.) umm: (2.03) right↓ (8.34) OK: shall we put it on the board↑
10	**Service User:**	Go on then↓
11	**Therapist:**	Yeah↑
12	**Service User:**	Yeah
13 14 15 16	**Therapist:**	Umm ok so the situation (5.02) umm ok (.) gig: on: night: urr (.) not crying too:: (.) question (1.20) right ok:↑ (2.02) so: umm:↑(.) the: urr: (.) so↑ I suppose the main: thing the main thing is not coming to the session↑ <isn't it really>
17	**Service User:**	**>**Yeah<
18 19 20	**Therapist:**	Yeah so ok (.) your thoughts were (2.00) wondering if [*therapist*] doesn't like me: (4.22) I'm attention seeking↑ (.) is that a thought↑ yeah↑ (7.20) <ok what else↑> (.)
21 22	**Service User:**	**<**I (.) don't (.) think> (1.50) I can: (3.00) I don't think I have enough (.) will power: (.) to change↑ (.) my self :
23 24	**Therapist:**	ok (10.40) Ok: umm: haven't got enough will power↑ (2.20) anything else↑ (8.37)
25 26 27 28	**Service User:**	I couldn't enjoy the thing I was meant to enjoy↑ I was looking forward to it and I didn't enjoy it and (.) I thought <I can't enjoy:> (.) it's all simple I just wanted to enjoy: it and I can't
29	**Therapist:**	Ok (1.50) ok (3.00) I can't enjoy this: ok (.) so:: behaviours↑
30 31	**Service User:**	Umm (.) I (.) when I was there well↑ actually I <removed myself from both situations didn't I↑>

32 **Therapist:** So you::

33 **Service User:** To a degr<u>ee</u> (.) I didn't really I didn't walk out of the gig↓(.)
34 but

35 **Therapist:** So what did you do sat down on the floor↑ or::

36 **Service User:** Yeah

Here the therapeutic aim is achieved because the service user constructs a description of their thoughts, feelings and behaviours during a precipitating event. However, the focus on the therapeutic aim ignores the service user's construction of hopelessness and despair.

Similar to extract one the therapeutic aim is accomplished in stages. First the therapist asks the service user to identify their thoughts (line 1). This questioning is in response to the service user's prior dialogue in which they discussed attending a gig and missing a session. The service user attends to the questioning with the preferred response; depicting their "thoughts". They also construct hopelessness and the self as potentially unlikable and lacking will power (see chapter ten extract five for a detailed analysis of the service user's responses). The therapist attends to this with an acknowledgement ("ok shall we put it on the board" line 8-9). This response neglects the important factors the service user has highlighted (i.e. a lack of willpower and being unlinked and attention seeking, line 5-7) and does not attend to the service user's construction of apathy and hopelessness (line 2-4). However this is in line with CBT practice because the therapist is eliciting details of a precipitating event to provide a description of the problem.

Secondly the therapist asks the service user about the situation in which the thoughts occurred ("ok so the situation" line 13-16), via indirect discourse ("Gig on night urr not crying" line 13-14) (Finlay and Robertson, 1990). This acknowledges what the service user has said, demonstrating active listening. However, the therapist then changes topic via a self-repair to talk about another situation ("not coming to the session", line 16). Here the questioning is formulated as a closed question, limiting the preferred response to a yes rather than eliciting information regarding what situation is important to the service user (line 15-16).

The therapist then attempts to elicit more details regarding the "thoughts" that occurred during the situation (line 18-20). The therapist lists the "thoughts" the service user

experienced. This list is situated as factual and as a statement rather than a question ("your thoughts were", line 18). The service user attends to this question by stating how they don't have the will power to change (line 21-22). As examined in chapter ten this is used to infer hopelessness and an inability to recover. The therapist does not attend to this disclosure. Instead the therapist responds with a continuer "anything else" (line 24). This dismisses the service user's plea for help and construction of distress, in the pursuit of the therapeutic aim.

In the final part of the extract the therapist's focus on the therapeutic aim at the expense of the service user's display of hopelessness and despair is most prominent (line 28). Between lines 25-28 the service user constructed apathy and an inability to enjoy simple things, to emphasis their distress and convey hopelessness. However, the therapist does not attend to this. Instead the therapist asks the service user about their behaviours to move the dialogue away from what the service user has highlighted as important, and towards the therapeutic aim ("I can't enjoy this ok so behaviours" line 29). This question is also composed directly and abruptly, unlike extract one where the therapist delicately and gradually built up to the question. This question accomplishes the therapeutic aim by encouraging the service user to talk about their behaviours (line 30-36). However, it neglects what the service user highlighted as important (i.e. apathy and a lack of will power). This fails to demonstrate empathy and understanding, which are highlighted as important notions for Item-Five on the CTS-r.

Extract seven is another example of how the therapist accomplishes the therapeutic aim but neglects other mediating factors highlighted as important to the service user. Extract seven is an example of the implementation of the CBT strategy *identifying NAT's*. The therapist's therapeutic aim is achieved in this extract because the service user constructs their thoughts regarding the event. However, the focus on the therapeutic aim (NAT identification) ignores the service user's display of hopelessness. Extract seven is an exchange between a service user and therapist during their fifth therapy session. In the dialogue prior to this extract the service user and therapist discussed the service user's apathy and negative thoughts regarding attending a music concert with their partner.

Extract seven - Service User SUF-R1 and Therapist T04:

1	**Therapist:**	So: what what makes you think you're unable to enjoy
2		things↑ (.) what what was the scenario:

Service User:	Umm: I don't actually know: what (.) it (.) was (.) but: while: we were there I (.) >part being there n getting there n you know: standing n waiting fine perfect lovely time n then< they played for a bit n it just suddenly flipped into my head (1.30) why: am I not enthusiastic about this:
Therapist:	Ok
Service User:	Why: am I completely: dead inside (h)
Therapist:	Ok: so they were a band were they↑
Service User:	Yeah
Therapist:	so (1.52) my: first question: is were they a good band↑
Service User:	**>**Yes yes they were good<
Therapist:	Right ok
Service User:	Yeah technically very good >yep< good show:
Therapist:	Ok so:: went to see band
Service User:	**>**Yeah<
Therapist:	Ok (3.03) thoughts:: so (.) were I'm not enjoying this↑
Service User:	**>**no<
Therapist:	**>**Yeah< (4.03) ok <I'm not enjoying this> (3.00) **>**what other thoughts are going through your head↑<
Service User:	That I should be↑
Therapist:	I should be: ok↓ that's a good one (4.20)
Service User:	I can't think of the reason why (.) I wasn't↑ cause I know I should have been: because I like them: n they were good: (.) and: urr: he was my boyfriend was there↑ n it was fine I don't know why: I (.) felt (.) those (.) things:
Therapist:	Ok so: would was there a thought there that why: am I not enjoying this↑
Service User:	Yeah: I did: think: that yeah↑

Here the therapist is implementing the CBT strategy *NAT identification*. The therapeutic aim is achieved in this extract because the service user constructs their thoughts regarding the event. However, the focus on the therapeutic aim ignores the service

user's display of hopelessness. This demonstrates a lack of empathy and understanding, which are highlighted as important notions for Item-Five on the CTS-r.

First the therapist attempts to elicit details regarding the situation in which the NAT has occurred. This is therapist initiated, in response to the service users formulation of the problem in the dialogue prior to this extract regarding being unable to enjoy going to a music concert (Perakyla *et al* 2008). This is accomplished by asking the service user about the scenario they were in when the thought occurred ("what was the scenario" line 1-2). The use of the term "makes" is used to create a two-part conditional structure which depicts a causal relationship between thoughts and situation. The questioning is again composed directly, and lacks the gradual and tentative building of the question that extracts one and two exhibit. The service user attends to this question by providing a description of the event "going to a gig" and their thoughts "why am I not enthusiastic about this" (line 3-7). The service user's response is composed hesitantly; via false starts (line 3) and invites confirmation from the therapist (line 4) (Pomerantz, 1984).

The service user then goes on to state "why am I completely dead inside" (line 9), which accomplishes apathy and distress. The use of the extreme case formulation "completely" emphasises the service user's point and their apathy. The therapist does not attend to this disclosure of distress. Instead they offer a small signal of acknowledgment "ok" and bypass the disclosure entirely by asking the service about the band at the gig (line 10-12). This steers the dialogue away from the service user's discloser (Clayman and Heritage, 2003). It is however in line with the therapeutic aim to gain more details about the precipitating event. The direct short closed questions limit the service user's responses to short answers ("yeah" line 11). Therefore, the questions elicit details regarding the band but do not encourage open dialogue from the service user (line 13-15). This questioning is used to build to a challenge of the idea that the service user should be excited in that situation (if the band were mediocre). This is why when the service user later identifies the thought "That I should be" (enjoying the gig) on line 22 the therapist responds with "that's a good one" on line 23, because it is the idea that the client should necessarily be enjoying the situation that they are seeking to question.

In the last part of the extract the therapist attempts to elicit details regarding the NAT that occurred during the "gig" (line 18-32). This is first presented as a statement that requires a yes or no response (line 18). The therapist then goes on to ask if there are any other thoughts (line 20). The question is structured as an open question allowing for

more dialogue around the NAT. However, this question lacks the tentative gradual building of the question seen in extracts one and two. It does however enable the identification of another NAT; which is the expected response (line 22). The repetition of the service user dialogue and encouragement ("I should be ok that's a good one" line 23) promotes forward movement of dialogue around the NAT, demonstrated between lines 24-27. However, the therapist ends the dialogue with a closed question formulated using quasi-direct discourse ("was there a thought there that why am I not enjoying this" line 28-29). This limits forward movement and the service user's response to yes or no (line 30) (Finley and Roberts, 1990).

7.3.4.1. Summary:

Overall both extracts six and seven accomplish the therapeutic aim because both therapists encourage the service user to provide descriptions of their problems; NAT's, emotions, behaviours, situations and physical sensations. What is interesting about these extracts is how the therapist accomplishes the therapeutic aim but neglects notions the service user highlights as important and fails to attend to the service users' emotion. This demonstrates a lack of displays of empathy and understanding, which are highlighted as important notions for Item-Five on the CTS-r. Furthermore, the therapist's questions are composed differently to extracts one and two where questions were composed gradually and subtly. Instead the questions in extracts six and seven were shorter and composed more directly and as closed questions requiring a yes or no response.

7.4 Discussion:

The analysis demonstrated the discursive features of effective and ineffective implementation of CBT strategies. For example, whether the strategies induce the preferred response, encourage dialogue, alignment, troubled responses and by evaluating the extent to which the CBT process gets done. Effective implementation of CBT strategies were characterised by four discursive features: (1) accomplishing the therapeutic aim via the elicitation of descriptions of the service user's problems, (2) attending to what the service user highlighted as important and the elicitation of emotion, (3) composing questions gradually and (4) creating joint narrative to infer empathy and understanding. Conversely ineffective implementation of the CBT strategies was characterised by five discursive features: (1) not accomplishing the

therapeutic aim, (2) dispreferred responses, (3) limited elicitation of dialogue, (4) troubled responses demonstrated through resistance or short answers and (5) closed questions. The analysis also examined troubled responses and demonstrated where the CBT strategies work but neglect other aspects of importance highlighted by the service users. Here the questions were shorter, direct and often required a yes or no response. In doing all of the above, the analysis provides an understanding of therapeutic processes by demonstrating effective ways of communicating in therapeutic interaction, to enable cohesion and therapeutic alliance. The contribution this has made to literature and the impact this could have for CBT are discussed below.

7.4.1. Implications for literature:

Overall this analysis provides a unique perspective regarding therapeutic interactions during CBT because to date no discursive research has looked at how cognitive behavioural strategies are implemented and attended to within CBT sessions. Furthermore, the current discursive literature that examined therapeutic interactions and their effectiveness has largely focused on systemic and psychodynamic therapy. This is the first analysis to look at how cognitive behavioural strategies are implemented and attended to within CBT sessions. In addition to this, to date no research has discursively analysed how items assessed via the CTS-r are constructed in talk. Overall the current analysis has identified three novel findings that contradict or expand previous literature regarding therapeutic interactions and the implementation of cognitive behavioural strategies.

7.4.1.1. The Discursive features of Effective CBT:

Firstly, in alignment with previous literature the current analysis found that therapists utilise various discursive devices during therapeutic interactions. These devices include quasi-direct discourse; adopting the service user's conversational style; creating joint productions; and creating a multi-authored narrative (Ferrara, 1992; Finlay and Robertson, 1990; Lewis, 1995; Couture, 2007; Kogan and Gale, 1997). However, the current analysis found that these discursive devices were more prominent in the extracts that effectively accomplished the therapeutic aim. In addition to the already established discursive devices, the extracts that effectively accomplished the therapeutic aim had other defining features. Firstly, they attended to the elicitation of emotion and notions the service user highlighted as important. Secondly, the therapist offered

encouragement and positive reinforcement. Lastly the therapist's questions were gradually formulated and composed as open questions, whereby the service user could respond freely. All of these features were used to encourage dialogue, demonstrate understanding and create empathetic responses.

7.4.1.2. When the CBT Process Does Not Accomplish The Preferred Goal:

The current analysis adds to previous literature regarding resistance and weak therapeutic alliances (Roy-Chowdhury, 2006). It demonstrated that the therapeutic aim was not accomplished when the CBT strategy did not elicit the preferred response, did not promote dialogue and there was evidence of therapeutic misalignment. When the therapeutic aim was not accomplished, the therapists' questions were composed as closed questions requiring a certain response; when the desired response was not given, it created misalignment between the therapist and service user. These questions were attended to with troubled responses; resisting the therapists' assertions or responding with short answers that attempt to stop questioning. Furthermore, troubled responses tended to occur when accounting for depression, if the terms "depressed" and "depression" were utilised or when the therapist challenged the service user's dialogue. This supports findings demonstrated in chapter nine that the lexicogrammatical differences between the terms "depressed" or "depression" can infer different things regarding aetiology, trajectory and prognosis. This can be problematic for therapeutic alliance. Here it was shown to have an impact on rapport and accomplishing the therapeutic aim. Therefore, future research needs to explore what the terms "depressed" and "depression" mean and when it is appropriate to utilise them in therapy.

However, it is not always as straightforward as the CBT agenda being effectively met or not, as this analysis demonstrates that the therapist could accomplish the therapeutic aim but also neglect other, arguably relevant factors, such as depictions of hopelessness and distress. The therapist did not attend to the elicitation of emotion or what the service user was highlighting as important. This demonstrated un-empathetic responses and demonstration of understanding, which are important discursive accomplishments according to the CTS-r. Furthermore, the therapist's questions were shorter and constructed more directly. In addition to this the questions were often constructed as closed questions requiring a yes or no response. This prohibits the service user from providing the dispreferred response but also prohibits the service user from answering openly and freely.

7.4.2. Conclusion:

Overall the current analysis identified effective, ineffective and questionable outcomes using CBT strategies and demonstrated the discursive features of effective and ineffective implementation of CBT strategies. An understanding of this could aid clinical practice and training. This is because the analysis examined troubled responses to CBT strategy implementation. This could aid clinical practice because it could provide knowledge regarding how to respond to troubled responses and how to avoid troubled responses in CBT. It also provides an understanding of how the therapist accomplishes the therapeutic aim as well as creating empathy and understanding, which are important discursive accomplishments according to the CTS-r. These findings therefore have implications for the CTS-r and the assessment of a therapist's skill. This is because no research has examined how items on the CTS-r are discursively accomplished or how therapists discursively inferred understanding and empathy whilst accomplishing the therapeutic aim. However the analysis focuses on trainee therapists and therefore the findings may not be transferable to therapists with more experience. This analysis does however add to the very limited discursive research regarding CBT and provide an insight into the discursive features of effective and ineffective implementation of CBT strategies. Future research should explore if these findings are similar across therapist experience levels or specific to trainee therapists. The clinical implications of this analysis are discussed in detail in Chapter eleven.

Chapter Eight – Avoiding the Terms "Depressed" and "Depression" in CBT Sessions about Depression

8.1 Overview:

This chapter will investigate the ways in which service users and therapists discursively construct depression, how these constructions are attended to and what these constructions are accomplishing in CBT sessions. Throughout the CBT sessions, service users and therapists actively constructed depression or a "depressed state" in various ways. A common occurrence across the sessions was that depression was talked about and described but the terms "depressed" or "depression", were absent from both the therapist and service user's discourse. Instead the service user and therapist oriented to, and discursively constructed, depression by drawing on a variety of alternative vocabulary (see Figure 1 below). The current analytical chapter focuses on how depression is discursively constructed without using the terms "depressed" or "depression". The analysis examines how these "alternative" constructions are used to manage accountability, construct identity, gain legitimacy for distress and present the service user as rational and their distress as justified.

Alternative Vocabulary:

"angry" "low mood" "het up" "nervous" "stressed" "stress" "irritated" "low" "cycle" "sad" "down place" "down" "sliding down" "spiral" "horrible" "bubble" "didn't want to live" "good stage" "empty" "a problem" "issues" "psychological problems" "it'" "it's" "cope" "well" "unwell" "not well" "under pressure" "anxious" "state" "mentally I feel" "sick" "really ill" "ill" "Illness" "upset" "struggling" "perfectionism" "hard to cope" "when I'm better" "nothing excites me" "rubbish mood" "something's wrong" "not right" "not nice" "alright" "awful" "useless" "feel bad" "negative thought"

Figure 2 – The Alternative Discourse Used by Therapists and Service Users to Construct Depression or a Depressed State

With regards to participant orientations, the current analysis follows Wetherell's position, in that for the purpose of this analysis the setting of the interactional talk (CBT therapy) is deemed important to the understanding of the discourse (Wetherell, 1998). The notion that all service users are scoring higher on depression assessment scales (PHQ-9) compared to other mental health conditions is also deemed relevant to understanding the interactional dialogue. Therefore it is the case that depression is

already relevant in this interactional dialogue. For a more detailed description of participant orientations see chapter six.

8.2 Introduction:

As chapter one demonstrated, the way depression is understood and conceptualised varies throughout history and within formal classification systems. Moreover, a widely accepted definition of depression is absent. This could be seen to imply that the concept of depression has a self-evident validity. A central point of contention is whether the concept of depression is ever value-free (Kendell, 1995). Indeed, the different constructions of depression have been used interchangeably in psychological literature and are divergent in formal classification systems such as the DSM and ICD (Malek, 2004; Pickering, 2006). This demonstrates a gap in the literature. Despite this ambiguity there is a growing body of research indicating that the way in which clinicians conceptualise mental health, guides their attitudes and reasoning. It also impacts their approaches to assessment, formulation, intervention and evaluation (Harland *et al*., 2009). Researchers have therefore suggested that clinicians' conceptualisations of mental health have significant clinical implications for their work with service users (Hugo, 2001; Stevens and Harper, 2007). The absence and ambiguity regarding the meaning of depression also has clinical implications for individuals with a diagnosis of depression. This analysis will therefore focus on how CBT therapists and service users discursively construct depression during CBT sessions for depression, in order to gain a better understanding of how depression is constructed and what these constructions accomplish in therapeutic interactions.

8.2.1. Discursive Psychology and the Construction of Depression:

A discursive approach to depression is necessary because of the varying understandings of depression over time. From a DP perspective talk about depression is not assessed to ascertain whether the speaker has depression or not, but what actions such talk performs. To date a limited amount of discursive psychological studies have addressed how depression is constructed in talk and text. The notable exceptions are presented in chapter four and an overview is presented below. Furthermore, no discursive psychological studies have been conducted about the construction of depression in UK therapeutic settings. The majority of discursive research has been conducted

retrospectively via interview and has largely focused on women (Crowe, 2005) and media depictions of mental health (see chapter four).

Discursive literature examining the constructions of depression has largely focused on explanatory frameworks and legitimising treatment choices. One of the most common findings of this research was that biomedical discourse was frequently utilised to construct depression (Pitcher 2013) (see chapter four). To recap, when individuals construct explanatory frameworks, they constructed depression as a biomedical condition and often compare depression to physical illnesses such as diabetes, cancer, heart disease, and broken bones (Schreiber and Hartrick, 2002). Physical illness is perceived as a legitimate excuse for inactivity and is often afforded empathy and tolerance (Burr and Chapman, 2004; Lafrance, 2007). Therefore, constructing depression as an 'illness like any other' is an attempt to incur typical responses given to physical illnesses (Issakainen, 2014).

When discussing treatment choices, mental health professionals also tended to draw upon medical discourse to construct depression. This enabled professionals to justify recommending pharmaceutical treatment options and justify the continuation of controversial treatment options with adverse effects (Thomas-MacLean and Stoppard, 2004). Mental health professionals, like service users, often compare depression to physical illnesses (Thomas-MacLean and Stoppard, 2004). This comparison was used to help professionals construct their approach to depression as routine.

Another common finding of previous literature was that depression is constructed as intrinsically immersed in the social context of individuals' lives (Burr, 2002; Calderón *et al* 2012). When individuals constructed explanatory frameworks, they often conceptualised depression as the result of social circumstances (Bennet *et al* 2003; Lewis, 1995a; Link *et al* 1999; Jorm, 2000). Mental health professionals construct depression in marginalised groups as inextricably linked to relationships, disadvantage and marginalisation (Körner *et al* 2011). Furthermore, mental health professionals in social care settings often framed their work in terms of addressing challenges confronted by all people moving through particular phases of life (Mitchell, 2009). Acknowledging social context reduces responsibility as it presents the cause of depression as not lying solely with the individual (Crowe, 2002).

Although biomedical and social discourses construct depression in different ways, they also share similarities. Both construct depression as an abnormality which can lead to individuals feeling like a failure and responsible for their depression (Wilson and McLuckie, 2002; Pitcher, 2013). Overall there is a limited amount of discursive literature examining the discursive constructions of depression and the research that has focused on explanatory frameworks and legitimising treatment choices. No discursive psychological studies have been conducted about the construction of depression in UK therapeutic settings. Furthermore to date, mental health professionals' and service users' constructions of depression have been examined separately and retrospectively via interview. No research has looked at how depression is jointly constructed and attended to during therapeutic interaction.

8.2.2. Research Question:

No discursive analytical studies have examined how service users and therapists jointly construct depression in UK therapeutic settings. Additionally, the previous literature suggests that depression is explicitly constructed and talked about (Pitcher, 2013; Calderón *et al* 2012; Crowe, 2002). However, the current analysis has found that depression is oriented to and talked about but the terms, "depressed" and "depression", are often absent from the service user's and therapist's discourse. This was a consistent finding throughout the therapy sessions and the rare deviant cases are presented in chapter nine. Therefore, the aim of the current analysis is to discursively examine how depression is constructed in CBT sessions, without using the terms "depressed" or "depression". It will also explore what the different constructions accomplish and how they are attended to within therapeutic interactions.

8.3 Analysis - How Service Users and Therapists Discursively Construct Depression in CBT Sessions by Utilising Alternative Discourse:

8.3.1. Overview of Key Findings:

In the vast majority of CBT sessions, depression is oriented to but the terms "depressed" and "depression" are absent. Instead, during CBT sessions the following four discursive features of talk about depression were identified. First, depression was constructed as a consequence of negative life events. This was used to construct depression as something

that does not occur without a trigger. Second, internal and external attributions for depression were blurred, to enable the therapist to manage accountability and situate recovery as within the service user's control. Third, depression was constructed as biological in origin. This positioned the service user as a passive victim who cannot be held accountable for their "faulty biology". Fourth, depression was constructed as an illness and the service user was positioned as being "ill". This was used to account for time off work, position the service user as misunderstood and construct identity. These strategies are introduced and discussed in turn.

8.3.2. Strategy One - Constructing Depression as a Consequence of Negative Life Events:

In extract one (a) and (b) the service user and therapist both orient to, and construct, depression without using the terms 'depression' or 'depressed'. Instead they draw on a variety of alternative terms which construct depression as non-pathological. The extract was split into two because extract one (a) demonstrates how the service user attributes depression to external life events and extract one (b) demonstrates how the therapist shifts accountability away from external events and back to the service user, increasing personal accountability for depression and recovery. Extract one (a) and (b), are taken from midway through the seventh therapy session. In the talk prior to these extracts the service user has been discussing how they have not been paid for the work they have done, so could not buy a coach ticket to visit their brother, but should be paid in the next few days.

Extract One (A) – Service User SUA-R1 and Therapist T01:

1 2	**Therapist:**	Yep (.) but it was as we were talking about last week like a snowball effect =
3	**Service User:**	=Yeah=
4	**Therapist:**	=So everything↓ was just (.) >not working<↓=
5	**Service User:**	**=**Exactly n=
6	**Therapist:**	=>n everything↓ (.) is just a big word<↓
7 8	**Service User:**	Yeah n it kept (.) getting worse↑ (.) it was the little things (.hhh) <like: (.) my: laptop:> (.) like I don't have a TV or

9		anything
10	**Therapist:**	Mmhmm=
11	**Service User:**	=I have my laptop
12	**Therapist:**	Mmhmm
13 14	**Service User:**	And (.) the charger for it broke↓ (h) and I was like ahh and it was right at like the time for a deadlines:↑
15	**Therapist:**	Yeah
16 17	**Service User:**	For a module I was finishing↓ (.) n I was just like↓ (.) ahh just (.) agh (.) so I was going to the library everyday
18	**Therapist:**	Mmhmm
19 20	**Service User:**	N sorting it out (.) n I live all the way on the other side so (h)
21	**Therapist:**	Mmhmm mmhmm
22	**Service User:**	So having to go to the library::
23	**Therapist:**	Good exercise↑ (h)
24 25 26 27 28	**Service User:**	That's very true↑ (.) that is very true↑ so (.) that was something↓ (.) but then (1.00) urr the only way I was contacting people was obviously since my phones:: disconnected (.) but I still have Wi-Fi:: connected to my phone (.) so I've been using my phone
29	**Therapist:**	Mm
30	**Service User:**	To sort of (.) remain: in contact with people
31	**Therapist:**	Yep
32 33	**Service User:**	Then my charger for my phone:: broke::(.) <and (2.01) that (.) sent me like (3.04) DOWN::::>
34	**Therapist:**	So that was almost like a last straw yeah↑
35	**Service User:**	°Yeah::°
36	**Therapist:**	Quite upset↓
37 38	**Service User:**	Yep (1.05) and (1.01) I sat on my bed and I cried:: (.) n I cried: because I couldn't even buy a new charger::↑

In extract one (a) the service user orients to and constructs depression (or a depressed state) without explicitly naming "depressed" or "depression". Instead they draw on a variety of alternative terms; "down" (line 33), and "it" (line 7) which are used to construct depression as non-pathological. The metaphor "down" (line 33) is drawn on to conjure an illustration of emotional distress (Khan *et al* 2007). These terms are also portrayed as consequences of fraught life events. This suggests the service user is orienting to depression which is constructed as something that does not occur without reason. This enables the service user to legitimise their distress and manage their accountability for depression because it shifts accountability onto external triggers (Bennett, 2003). Orienting to depression or a depressed state through the metaphor "down" orients to a need for delicacy and demonstrates that the label of depression is potentially negative or taboo.

Throughout extract one (a) the service user lists a number of external triggers that contributed to their emotional distress (lines 7-23) and constructs these seemingly everyday events, as fraught life events that have caused distress. The listing of the fraught life events (lines 7-23) builds the service user's case by presenting the distress as caused by multiple events. This is aided by the use of interjections (lines 13 and 17) which produce an illustrative expression of the distress caused. Constructing life events as distressing is used to invoke empathy from the therapist, illustrated on lines 34 and 36. The fraught life events are also provided as an explanation for distress. This positions the service user's distress as justified because an external trigger is the cause. It also creates a "victim discourse" whereby the service user cannot be held personally responsible for their depressed state (Drew *et al* 1999).

The therapist initially responds to the service user's construction of fraught life events causing distress with agreement; "mmhmm" and "yeah" (lines 10, 12, 15, 19, 22). However, on line 24 the therapist responds with a lack of agreement ("good exercise (h)"). The therapist is benefit finding by reformulating the negative into a positive. Benefit finding downplays and minimises the service user's distress (Potter, 1996). This could be to encourage the service user to move on to another topic. However, the service user responds by providing a stronger justification for why these events are causing them emotional distress and are therefore not beneficial (25-33). Between lines 25-33 the service user builds a case as to why the phone is important, to disavow the therapist's minimisation of their distress. This culminates on lines 32-33 where the service user situates the phone as a direct cause of their emotional distress. This again constructs

depression as something that does not occur without a trigger (De Shazer, 1997; Harvey, 2012). It also positions the service user as unaccountable for their depressed state (Drew *et al* 1999).

8.3.3. Strategy Two – Blurring Internal and External Attributions for Depression to Manage Accountability:

Extract one (a) demonstrated how the service user goes to rhetorical lengths to build their case that their emotional distress is caused by external triggers (line 37-38). Extract one (b) comes directly after extract one (a). Here, the therapist blurs internal and external attributions for the service user's emotional distress and shifts accountability back to the service user. It also situates recovery within the service user's control.

Extract One (B) – Service User SUA-R1 and Therapist T01:

39	**Therapist:**	Mm
40	**Service User:**	Because I hadn't: been: paid:↓
41	**Therapist:**	Gosh↑
42	**Service User:**	N I was just (.hhh) (hhh)
43 44 45 46 47 48	**Therapist:**	N you know↑ I want to acknowledge that↑ but (.) and:: I want to say almost but but and:: (.) I'm looking at you right now↑ (2.50) and what I'm hearing is that you↑:: (.) obviously what you↑ sharing with me you have dealt with a lot of these things by (1.0) brainstorming it by looking at it (.) n actually recognising:: (.) what has triggered all of it↓
49	**Service User:**	Mm (1.02) exactly
50	**Therapist:**	And: that was not your fault↓=
51	**Service User:**	=Mm
52 53	**Therapist:**	Your reaction::↑ (.) <to the things that were happening then> (1.05) was your: personal reaction↓ (.)
54	**Service User:**	mm
55	**Therapist:**	or reactions::
56	**Service User:**	mm

57	**Therapist:**	yep (.) but the trigger↑ (.) n what has actually happened↑
58		(.) that wasn't: (.) <your fault at all:↓>
59	**Service User:**	mm yeah (1.50) exactly (.hhh)

Like extract one (a) the therapist again orients to depression without utilising the terms "depressed" and "depression". Instead they discursively construct depression by drawing on a variety of alternative terms; "it" (line 48) and "reaction" (line 53 and 55). These alternative terms are again situated as consequences to fraught life events. Suggesting that an external trigger is responsible for the service user's depression, allows the therapist to manage accountability for the service user's distress. This has implications for recovery because it situates recovery as out of the service user's control. However unlike the earlier part of the extract, the therapist now goes on to subtly blur internal and external attributions for distress and increases the service user's personal accountability for depression.

When shifting accountability from external events to internal attributions, the therapist orients to a need for delicacy. This is demonstrated through disclaimers, gradual building to the point and hesitant and intimate discourse. The use of "you" throughout this section of interaction subtly changes the focus from external events, to the service user. Thus indicating that the service user may have control over the way they have "dealt with a lot of these things" (line 46-47). Delicately combining internal and external attributions creates an ideological dilemma whereby the therapist manages two competing repertoires; *depression being attributed to external life events* and *depression being attributed internally to the service user*. Within this ideological dilemma the therapist carefully manages accountability. Initially the therapist explicitly rejects the premise that the service user is to blame for their adverse circumstances (line 50). However, rejecting this premise also insinuates that blame attributed to the service user needs to be defended. The therapist then goes on to reformulate the service user's distress as their "personal reaction" (line 52-53) (Perakyla *et al* 2008). This consequently shifts accountability onto the service user rather than the external trigger. When managing this ideological dilemma the therapist constructs depression as a "reaction" (line 52) which could be viewed as externally attributed. However, the use of "your" and "personal" (line 52-53) before the term reaction, increases the service user's accountability. Although the therapist situates the service user as accountable for their "reaction", they also construct the external "trigger" as out of the service user's control (line 57-58). Constructing

depression in this way allows the therapist to delicately position the service user as not at fault (for the trigger) but as responsible for their reaction to the precipitating events and ultimately in control of their recovery.

8.3.4. Strategy Three – Therapist's Utilisation of Alternative Discourse to Construct Depression:

In extract one "depression" was subtly oriented to through alternative terms such as "down" and "reaction". The next section of analysis clearly demonstrates that while the terms "depressed" and "depression" are absent, the therapist is orienting to and constructing depression. The second extract features an exchange between a different service user and therapist. The exchange takes place during the service user's third IAPT session. The service user has just been discussing problems at work, not wanting to go out because they will be in a "rubbish" mood and trying to act normally in front of friends but this consequently makes them feel "fake".

Extract Two - Service User SUB and Therapist T02:

1	**Service User:**	Nothing exciting me ::(.hhh)
2	**Therapist:**	Mmm(.hhh) (.) it's not (.) uncommon↓ at all (.) when
3		you're feeling down::↓ (.) that things that would
4		normally::↑ make you feel happy:: n lift your mood↑ (.)
5		just don't (.) <seem to be (.) quite↓ doing (.) the trick> (h)
6		(hhh)
7	**Service User:**	Mmm::
8	**Therapist:**	So (.) there's <u>that</u> (.) which is to do with just:: ><u>f</u>eeling low<
9		(1.0) some people view it more (.) as umm:: (.) like a
10		chemical imbalance↑ (1.0) so (.) that it almost takes a little
11		bit <u>more</u> (.) <u>oomph</u>:: to lift your (.) chemicals up to (.) to
12		<u>feel</u> <how you'd normally feel> and sometimes it just takes
13		a bit of time for them to (1.0) <creep back up>
14	**Service User:**	Mmm:

Here the therapist and service user both talk about depression without explicitly naming it; even when constructing a biomedical explanation and definition of depression. The service user utilises the phrase "nothing excites me" (line 1) to convey a depressed state, whereas the therapist uses the terms "down" and "low" (lines 3 and

8). These metaphors present depression as non-pathological through the use of non-medical colloquial terminology. However, when the stretch of talk is taken, as a whole the therapist is able to construct depression as biomedical by suggesting something is wrong with the service user's biology. The use of biological terminology, but the absence of the terms "depressed" and "depression", demonstrates that depression is oriented to but not explicitly named. This finding will be examined in more detail below.

In the first part of the extract the service user conceptualises being depressed by describing apathy "nothing excites me" (line 1). The extreme case formulation (line 1) is used to depict the service user's distress as severe. By conceptualising being unhappy through the use of the term "excites" (line 1), the service user is able to talk about being depressed without explicitly using the term. The service user's disclosure is oriented to by the therapist as depressive and responded to as a disclosure of being depressed. This can be seen in the therapist's response (lines 2-5) which is constructed as a definition of depression or potential diagnosis. This definition of depression is used to construct the service user's experience as out of the ordinary but a normative and expected symptom of depression.

After defining depression, the therapist provides an explanation for depression (lines 8-13). This is again achieved without explicitly using the terms "depressed" or "depression". Instead the therapist appears to be using the terms "low" (line 8) and "down" (line 3) interchangeably to conceptualise depression. These metaphors present depression as non-pathological. However, the therapist constructs depression as biological in origin and a consequence of a "chemical imbalance" (line 8-10). This is composed in a hesitant manner, signalled through the frequent use of pauses and utterances (line 9) and starts with a non-committal statement "some people view" (line 9). This statement distances the therapist and service user from the statement and presents the therapist's explanatory discourse as somewhat corroborated but not widely accepted (Potter, 1996). The use of biological terminology, but the absence of the terms "depressed" and "depression", demonstrates that depression is oriented to but not explicitly named (line 10). Instead the therapist utilises terminology such a "feeling low" (line 8) and "normally feel" (line 12) to depict depression and to elucidate the consequences of faulty biology. Utilising biomedical terminology to construct depression as a consequence of a "chemical imbalance" (line 8-10) is used to convey that something is wrong and allows the therapist to manage blame and accountability. The therapist avoids blaming the service user for their distress and instead positions

the service user as a passive victim of biology. This reduces the service user's accountability for their distress because the service user cannot be held accountable for faulty biology (Drew *et al*, 1999). However, a consequence of this is that it situates recovery as out of the service user's control.

The therapist situates recovery as dependent on biology, specifically a rise in chemicals (line 10-12). When constructing recovery the therapist again draws on non-medicalised metaphors (line 10-11). Although the therapist's talk is directed at the service user, the therapist manages accountability by constructing depression as having ontological status in the form of brain chemistry (line 13). This manages the service user's accountability because it positions them as a passive victim of biology and recovery as out of their control (Speed, 2006; Pitcher, 2013). This is used to accomplish rapport and reassure the service user by tentatively constructing their experience as an expected consequence of faulty biology. This is an interesting suggestion, given that the service user is receiving a talking therapy rather than a biomedical therapy. Therefore this is contrary to the theoretical underpinnings of CBT.

8.3.5. Strategy Four - Depression is Constructed as an "Illness" to Account for "Atypical" Behaviour and to Manage Identity:

In the previous extracts depression was constructed as the consequence of external life events or a chemical imbalance. This situated the service user's emotional distress as something that requires a social or biological trigger. This section of analysis will demonstrate how depression is constructed as the causal factor of distress and atypical behaviour, and how the service user utilises the term "ill" to depict depression as pathological.

The third extract is an exchange between a service user and a therapist. Prior to extract three, the service user had been discussing a return to work meeting with their boss that had taken place the previous week. In extract three the service user is depicting how their boss has interpreted their time off work. In this extract depression is constructed as an illness and the service user constructs them self within the subject position of "ill individual" (Widdicombe and Wooffitt, 1990; Wood and Rennie, 1994; Lafrance, 2007).

Extract Three - Service User SUC-R1 and Therapist T03:

1	**Service User:**	umm: (1.0) so: we discussed some of that (1.0) <he
2		obviously thinks (.) that I went off sick (.) because:↑>(1.0)
3		he challenged me (hhh) (h)
4	**Therapist:**	oh:↑ right↑
5	**Service User:**	rather than the fact (.) that (.) I↑ was really: ill (h) =
6	**Therapist:**	= yeah:
7	**Service User:**	and what he said (1.0) no↓ (.) it didn't help: =
8	**Therapist:**	=[mmm
9	**Service User:**	[but↓ (.) I didn't go off sick <because he challenged me>
10	**Therapist:**	did (.) did you =
11	**Service User:**	**=** yeah so
12	**Therapist:**	vocalise: that
13	**Service User:**	no (.) no (.) I said I was **ill:↓ =**
14	**Therapist:**	= [Mmm
15	**Service User:**	[and I couldn't cope with what you were saying to me↓ (.) I
16		said (.) you know (.) if you (.) I said I don't have a problem
17		with confrontation↑
18	**Therapist:**	mmmm =
19	**Service User:**	= you know (.) usually it would make me angry↓ I wouldn't
20		(.) you know↑ (.) >take a day off sick↑< (h)
21	**Therapist:**	Yeah

In extract three, depression is constructed as an illness to account for the service user's time off work and potentially inappropriate behaviour. This enables the service user to position them self as misunderstood and their boss as intolerant and un-empathetic for not coming to the same conclusion. As well as managing accountability for behaviour that could be perceived as inappropriate or irrational, this also allows the service user to gain empathy and understanding from the therapist.

The service user constructs them self as misunderstood by others; in particular by their boss. This is accomplished by justifying their time off work and discrediting alternative versions. The alternative version "I went off sick because he challenged me" (line 2-3) is threatening to the service user's identity because it situates their time off work as unjustified and the service user as irrational. The alternative version is constructed as non-factual and an unsubstantiated claim (line 2). The construction of depression as an illness is presented as a competing version of events (line 5).

In the previous extracts depression is constructed as a response, an emotion or a verb that requires an explanatory phrase (Extract one: line 32-33). However in extract three, the discourse associated with the sequence "I was really ill" (line 5) and "I was ill" (line 13) lacks a set of triggers and is instead constructed as the explanation for depression (McLeod, 1997). This enables the service user to situate their behaviour as a consequence of being ill; which subsequently allows the service user to position them self as misunderstood by wider society, and situates their symptomology as misinterpreted by others as inappropriate behaviour. "Sick" and "ill" individuals are often afforded empathy, encouragement and patience (Lafrance, 2007). Furthermore, "illness" is often afforded legitimacy for inactivity (Lafrance, 2007). Therefore, constructing depression as an "illness" is used as an attempt to incur the typical responses given to physical distress and situates their symptomology as misinterpreted by others.

The service user goes on to explicitly deny the boss' alternative version of events (line 9) and presents being "ill" as a common sense version of events (line 13). This is accomplished through a lack of detail which works to present the service user's construction as factual and common sense. Subsequently positioning those who do not come to the same assumption, as misinformed. The therapist does not dispute this construction nor do they probe for more information. The therapist attends to the construction of depression as an illness with an acknowledgment (line 14). The service user also positions being ill as impacting their ability to cope with difficult situations (line 15). This dialogue further constructs depression or "being ill" as the causal factor for their time off work. The service user reframes their reaction as a consequence of illness and serious enough to require time off work (line 19-20). The service user presents taking time off work as a quantifiable measure of distress. This situates the service user's time off work as justified and others as un-empathetic for questioning the legitimacy of their distress. Overall in extract three the service user is eliciting sympathy from the therapist for the difficulties depression is creating in their (work) life. The service user

assumes that themselves and the therapist, share the repertoire depression as 'illness', but constructs the world outside (e.g. work) as not fully understanding or appreciating this or the difficulties of depression.

The fourth extract builds on the arguments presented in extract three where the service user utilises the term "ill" to depict depression. However, in extract four this construction is used to argue and establish what type of person the service user is. Constructing depression or being "ill" as separate from the service users identity, presents their behaviour as out of character. This allows the service user to manage accountability for potentially atypical behaviour because it presents the service user as ill rather than intrinsically flawed. This allows them to shift accountability for behaviour onto their depression (Harvey, 2012; Mintz, 1992; Warner, 1976). The fourth extract is an exchange between a service user and therapist in their fourteenth therapy session. In the discourse immediately prior to extract four the service user was discussing their time away with friends, who they described as parent figures. The service user also discussed their apprehension about returning to work because of what their work colleagues might think of them.

Extract Four – Service user SUC-R1 and Therapist T03:

1	**Service User:**	because they know me really <u>well:↓</u>
2	**Therapist:**	yeah
3	**Service User:**	You know (.) they've reminded me who: <u>I am</u>↓ (.) <rather
4		than what I'm **<u>not</u>**:> whereas everyone <u>here</u>
5	**Therapist:**	Mmmhmm:
6	**Service User:**	Is (.) just: telling me what I'm not↓ (1.0) whereas↑ they
7		can <u>go</u> (.) <u>no</u> that's (1.0) you're doing that because your ill↑
8	**Therapist:**	Right↑ yeah:
9	**Service User:**	you know (.) >that's: <u>not</u> you<

In the first part of the extract the service user's main focus is to construct their identity and validate this construction. To accomplish validation the service user presents their friends as a trustworthy and credible source regarding the service user's identity; compared to the service user's work colleagues. This is achieved by situating the service

user's friends as knowing the service user better (line 1). This in turn creates an implied lack of knowledge about the service user from work colleagues. This is used to present alternative constructions regarding the service user's identity as inaccurate and tenuous. After establishing the credibility of the two sources ("friends" and "everyone"), the service user compares and contrasts the two competing discourses regarding identity (line 3-7). The credible construction of identity is presented as "who I am" (line 3). The non-credible construction from "others" is presented as "what I'm not" (line 4 and 6). This presents the perception of the service user by "everyone" at work as negative; and that the service user attributes their inability to the illness, and draws upon their friends to corroborate this. This in turn positions the service user as misunderstood by those who do not know them well. In doing so, the service user may be attempting to solicit empathy from the therapist and recognition that they are treated unfairly (line 5).

Constructing depression as an illness and themselves as being ill, presents negatively evaluated behaviour as atypical rather than intrinsically flawed. This construction excludes social environmental factors and minimises the role of the individual in their illness experience. This consequently situates the service user as unaccountable for their behaviour (Cassell, 1976; Harvey, 2012; Mintz, 1992; Warner, 1976). It also constructs depression as possessive, consuming and controlling. This is similar to discursive conceptualisations of other disease entities which are often comprehended as objects that intrude on the self (Cassell, 1976; McLeod, 1997). Again the service user is using the repertoire "illness" to elicit sympathy from the therapist for the difficulties depression creates, and to conceptualise the world outside (e.g. work colleagues) as misinterpreting their symptomology as negative behaviour.

In the last part of the extract the service user constructs who they are not. This allows the service user to dismiss depression as a trait and part of their identity (line 9). This further reinforces that their behaviour is out of character and in turn constructs depression as responsible (Bennett *et al* 2003). This enables the service user to manage personal accountability for what might otherwise be perceived as incompetence. The use of "that's" to describe behaviour that is out of character allows the service user to disassociate themselves from their behaviour (line 9). This terminology also gives depression ontological status (line 9). This is similar to conceptualisations of diseases and disease symptoms which are often signified by the impersonal "it" and "the" (Cassell, 1976). This allows the service user to present depression as consuming and

dismiss assertions that they, or social environmental processes, are responsible for the development of depression. The therapist does not question the service user's construction of depression as an illness. Instead, the therapist responds with signals of agreement (line 5 and 8). This could be because constructing depression as an illness has rhetorical power because medicine is often associated with truth and objectivity (Lafrance, 2007). This construction of depression aligns with medical discourses which psychological therapists are inadvertently embedded in, due to the zeitgeist of mental health conceptualisation at this time.

8.4 Discussion:

8.4.1. Overview of Results:

This analysis has identified that during CBT sessions service users and therapists oriented to and talked about depression but the terms, "depressed" and "depression", were absent from the interactional dialogue. This analysis also identified that service users and therapists constructed depression in various ways, by drawing on four different discursive strategies. The first constructed depression as a consequence of negative life events; the second demonstrated how the therapist subtly blurs internal and external attributions for depression to manage accountability; the third constructed depression as biological in origin; the fourth constructed depression as an illness and the service user within the subject position of "ill individual". Furthermore, depression was constructed and oriented to but the terms "depressed" and "depression" were absent from both the service users and therapists' discourse.

8.4.2. Implications for Literature:

This analysis provides a unique perspective regarding the construction of depression, because to date no discursive research has looked at how service users and therapists jointly construct depression during therapeutic interactions. This analysis is the first to examine how these constructions are jointly attended to and what they accomplish. The tendency to focus on the service user was because the service user conceptualised depression more frequently in the interaction, and the analysis reflects wider patterns within the data. Furthermore, this is the first analysis to look at how depression is constructed in a UK therapeutic setting. Overall the current analysis has identified four

novel findings that contradict or expand previous literature regarding the construction of depression. These novel findings are discussed in turn below.

Previous literature suggests that depression is explicitly constructed and talked about. However, the most notable novel finding of this analysis was that depression is oriented to and talked about but the terms, "depressed" and "depression", were absent from the service user's and therapist's dialogue. Instead service users and therapist's utilised alternative terms such as "down" "low" and "ill" to construct depression. This is interesting as the service user is in therapy and depression was the predominant factor according to the GAD-7 and PHQ-9. Even more striking was the absence of the terms "depressed" and "depression" when constructing a biological definition of depression. This highlights that during therapeutic interaction depression is talked about and constructed but the terms "depressed" and "depression" are absent. This could indicate that the term depression is potentially negative or stigmatising. The absence could also be because service users and therapists are adhering to public texts' conceptualisations of depression, in which depression is constructed as dangerous and negative, and individuals with a diagnosis of depression are constructed as blameworthy and in control of their illness (Arboleda-Flórez and Stuart, 2012). Therefore, the service users and therapists might be managing these dilemmas in talk by avoiding the term depression.

Analogous to previous discursive literature the current analysis found that depression was constructed as either a consequence of biology or fraught life events (Calderón *et al* 2012; De Shazer, 1997; Harvey, 2012). However, this was accomplished without utilising the terms "depressed" and "depression". This is interesting because it demonstrates that service users and therapists are able to construct depression without utilising the terms. In addition to this previous research was conducted retrospectively via interview and focused on justifying treatment choices and explanatory frameworks. Constructing depression as a consequence of life events in this analysis was used to shift the focus away from the service user and reduce accountability by implying that the cause of depression does not lie solely with the individual. The service user is therefore managing their accountability for depression by constructing their emotional distress as externally attributed. Although constructing depression as biological in origin was a common finding in previous literature, it is unexpected in this analysis because the therapist is from a cognitive behavioural paradigm. Previous discursive literature found this strategy was employed by mental health professionals to justify

pharmaceutical treatment or argue that their approach is routine. However, biological terminology was used by the therapist in this analysis to manage accountability by positioning the service user as a passive victim who cannot be held accountable for their "faulty biology". A consequence of this is that it situates recovery out of the service user's control, which is contrary to CBT's theoretical underpinning.

Previous literature found that individuals compared depression to an illness, to incur empathy and tolerance often afforded to sick individuals (Issakainen, 2014; Schreiber and Hartrick, 2002). In opposition to this within the current analysis depression was constructed explicitly *as* the illness, rather than compared to an illness, in an attempt to incur these typical responses afforded to sick individuals. This ultimately positioned those who did not view depression as an illness as intolerant, positioned the service user as misunderstood and their time off work as legitimate. Furthermore, "depression as an illness" was constructed as a common-sense notion, with no need for explanation. Unlike constructing depression as a consequence of external factors or faulty biology, "being ill" was constructed as the causal factor because it lacked a set of triggers. This marginalised the role of the service user in their illness experience.

Convergent with previous CA literature regarding psychotherapy, the therapist utilises the CA concept of reformulation to pose new understandings of accountability and distress (Perakyla *et al* 2008). This is demonstrated in extract one A where the therapist reformulates the service users distress over their laptop into "good exercise". It is also demonstrated in extract one B where the therapist reformulates the service users denial of accountability over their distress into accountability for emotions felt but lack of accountability for external triggers. However, this analysis diverges from CA research in that it did not find the reformulations to be singled by perspective markers. Furthermore this analysis diverges further from CA in that it is examining non-obvious ways in which language is involved in constructing depression.

To date discursive literature has not examined how service users and therapists jointly construct depression. An interesting finding from this analysis was that when attending to the service users' construction of depression the therapist carefully manages accountability and blame. In extract one (B), the therapist attended to the construction of depression as a consequence of negative life events by blurring the conception of internal and external attributions. This created a dilemmatic talk whereby the therapist carefully manages blame. They subtly shifted accountability back to the service user by

making external attributions internal. This increased the service user's personal accountability for depression and their recovery. The construction of depression as both internally and externally attributed is a novel finding. Although the notion that depression can be both internally and externally attributed is common knowledge, previously these attributions were drawn on separately. However, in this analysis they are used simultaneously to manage blame and accountability. A novel finding in this analysis is that when attending to the service user's construction of depression, the therapist manages accountability on behalf of the service user. This could be to accomplish empathy and rapport or because the service user is positioned as vulnerable and unable to manage accountability themselves. This has implications for clinical practice because shifting accountability on to the service user enables the service user to take ownership of recovery and situates change as possible. This should be highlighted to trainee CBT therapists, as it would provide them with strategies to combat issues of accountability in therapy.

Although the different discursive strategies identified construct depression in different ways, they also share similarities. They construct depression as an abnormality that needs to be accounted for. Thus, the therapists and service users are trying to construct depression as within the range of "normal" human experience. Managing accountability for depression and potentially atypical behaviour has its limitations because it consequently positions depression and the service user's behaviour as something that needs to be accounted for. Managing accountability was a key theme within this analysis.

8.4.3. Implications for Clinical Practice:

The absence of the terms "depressed" and "depression" has clinical implications. Firstly, it demonstrates that the label of depression is potentially negative or stigmatising and the terms are taboo. The absence could be because service users and therapists are adhering to public texts' conceptualisations of depression, and are therefore managing dilemmatic talk by avoiding the term depression. In order to understand why the terms "depressed" and "depression" are avoided during therapeutic interactions, future research needs to focus on what the terms mean to lay individuals and mental health professionals. It also needs to examine CBT training to gain a clearer understanding of how depression is constructed during teaching. Secondly, this analysis demonstrated that depression was constructed in various ways; an illness; consequence of chemical

imbalance and a consequence of fraught life events. This suggests that there is uncertainty around the concept of depression. The lack of a universal definition of depression and the changing conceptualisation of depression throughout history may have contributed to this uncertainty. This further emphasises the need for more research to focus on what the term "depression" means to lay individuals and mental health professionals. Overall the absence of the terms and varied constructions of depression could have implications for clinical practice. Firstly, it could demonstrate unease around the terms or uncertainty. Both of these could have an impact of rapport and treatment outcome. Therefore, CBT training should highlight this as a potential issue. The findings from this analysis have limitations regarding generalizability because the dialogue is from a specific context (CBT sessions) and from a specific sample (trainee therapists). Therefore future research should look at why these terms are absent in therapeutic interaction and examine if this finding is consistent across therapeutic disciplines or specific to CBT.

8.4.4. Conclusion:

To date no discursive analytical studies have examined how service users and therapists jointly construct depression and attend to these constructions during therapeutic interactions. This analysis has identified four strategies whereby depression was constructed in various ways to manage accountability, present behaviour as justified and position service users as passive victims of illness or circumstance. These strategies simultaneously situate recovery as out of the service users' control. Therefore counter strategies can be developed to combat this issue in therapy. While discursive psychology does not offer a simple solution to the lack of a widely accepted definition of depression, a thorough understanding of how depression is constructed may allow for a better understanding of depression. It would also demonstrate the implications that a lack of a widely accepted definition of depression has had on individuals with a diagnosis of depression and mental health professionals. The current analysis identified that depression was constructed and oriented to but the terms depressed and depression were absent from the service users and therapists discourse. This has practical implications for CBT training and the development of teaching that combats stigma and ambiguity around the term depression. Further research also needs to be conducted on why the terms are absent and what the term depression means to service users and therapists.

Chapter Nine - Utilising the Terms "Depressed" and "Depression" - How Service Users and Therapists Discursively Construct Depression in CBT Sessions:

9.1 Overview of Chapter:

Chapter eight demonstrated that during therapeutic interactions depression was often talked about and described but the terms "depressed" or "depression" were absent from both the therapist and service user's dialogue. Instead the service user and therapist oriented to, and discursively constructed, depression by drawing on a variety of alternative vocabulary. Although it has been established that the terms "depressed" and "depression" are utilised infrequently during CBT sessions, occasionally the service user and therapist do use these terms. Therefore, the current chapter will examine how the terms "depressed" and "depression" are used and attended to in CBT sessions. It will examine how depression is constructed during therapeutic interactions and the rhetorical and lexicogrammatical differences between the terms "depressed" and "depression". It will also consider how these terms are utilised to construct identity, manage accountability and legitimise behaviour and distress. What is interesting about this section of analysis is how the service users and therapists orient to a need for delicacy when utilising the terms "depressed" and "depression".

9.2 Introduction:

A limited amount of discourse analytic research has focused on the deconstruction of clinical categories and how lay individuals discursively construct depression. Furthermore, no discursive analyses have been conducted regarding the construction of depression during therapeutic interactions in the UK. However, a large body of literature addresses mental health related discourse without adopting a discursive methodology. To date the qualitative research regarding depression, has largely adopted narrative analysis and was conducted retrospectively via interviews (Kuhnlein, 1999; Levitt, 2002). A key finding from linguistic examination found that individuals frequently situated their accounts of depression around two recurring constructs: "I am depressed" and "I have depression". These constructs represent two ways of characterising experience; that of "being" and that of "having" (Fromm, 1979). The statement "I am depressed" was often used to portray depression as a reaction to

negative life events (De Shazer, 1997; Harvey, 2012). However, the statement "I have depression" accomplishes possession and therefore constructs depression as an external object (Fleischman, 1999). This is similar to conceptualisations of other disease entities which are often comprehended as objects that intrude on the self (Cassell, 1976; McLeod, 1997). Overall non-discursive examination suggests that accountability is managed in depression discourse. However, a discursive evaluation of how depression is constructed would examine and inform how accountability is managed during this construction and what these two ways of characterising experience accomplish during therapeutic interactions.

To date no discursive analyses have been conducted regarding the construction of depression in UK therapeutic settings. Furthermore, to date mental health professionals' and service users' constructions of depression have been examined separately and retrospectively via interview, and have focused on explanatory frameworks, treatment choices and diagnosis. Discourse analytic studies focusing on diagnosis found that being given a diagnosis of depression was constructed as bringing relief, validation and legitimisation because it validated assertions that there was a problem that required medical treatment (Issakainen, 2014; Lafrance, 2007; Wisdom and Green, 2004). A diagnosis enabled individuals to construct their distress as 'serious' and 'real', as it had a recognisable aetiology ('they even have a name for it') (Lafrance, 2007). Diagnosis was also used to ward against having their experience constructed as their own subjective misinterpretation (Lafrance, 2007). Therefore, diagnosis was drawn on to defend speakers' experiences and personal identities (Lafrance, 2007).

The limited discourse analytic research focusing on the construction of depression found that depression was often constructed as a disease and biomedical discourse was frequently used to construct depression (Pitcher, 2013). Biomedical discourse was used to construct depression as an independent entity located within the individual or body and ignored external causal factors (Wilson and McLuckie, 2002; Lafrance, 2007; Georgaca, 2013; Pitcher, 2013). Individuals with a diagnosis of depression often constructed depression as a result of a hereditary biological deficiency, specifically neurotransmitter dysfunction (Johansson *et al* 2009; Lafrance, 2007). This positions individuals as blameless victims of genetic inheritance who cannot be held accountable for their depressed state (Drew *et al*, 1999). Within biomedical discourse 'personal flaws' and 'biological flaws' are presented as competing discourses; whereby a medicalised account ignores any consideration of how life events could have aided

depression (Lafrance, 2007). More specifically, mental health professionals' characterised depression as 'true depression', when it could not be attributed to life events and suggested that individuals who do not use antidepressants do not suffer from 'true' depression (Thomas-MacLean and Stoppard, 2004; Oliphant, 2009). Depression was occasionally constructed as intrinsically linked the social context of individual's lives (Burr, 2002; Calderón *et al* 2012). When individuals with depression constructed explanatory frameworks for their experiences, they often conceptualised depression as the result of social circumstances (Bennet *et al* 2003; Lewis, 1995a; Link, *et al* 1999; Jorm, 2000). Mental health professionals constructed depression in marginalised groups as inextricably linked to social relationships, social disadvantage and marginalisation (Körner *et al* 2011). Acknowledging the social and cultural context of depression was used to reduce responsibility as it depicted the cause of depression as not laying solely with the individual (Crowe, 2002).

As demonstrated above there is a limited amount of discursive literature focusing on the construction of depression and to date no discursive research has focused on the construction of depression during therapeutic interaction. The discursive literature that has looked at the construction of depression has examined this retrospectively via interview or discussion forums. It has not examined how service users and therapist jointly construct depression, and how these constructions are attended to. Furthermore, non-discursive literature has found that depression is constructed as either an experience of "having" or "being" but no discursive research has examined what these different constructions are accomplishing in therapeutic interactions.

9.2.1. Research Question:

In addition to there being no discursive literature focusing on the construction of depression in UK therapeutic settings, previous literature suggests that depression is explicitly constructed and talked about. However, the previous analytical chapter found that depression is oriented to and talked about but the terms, "depressed" and "depression", are often absent from the service user's and therapist's discourse. Therefore, the aim of the current analysis is to discursively examine the rare occasions the terms "depressed" and "depression" are utilised during therapeutic interactions. It will also explore what the utilisation of the terms accomplished and how they are attended to within therapeutic interactions. It will explore how depression is constructed and attended to, as well as consider how these terms are utilised to

construct identity, manage accountability and legitimise behaviour and distress. A noteworthy facet of the proceeding analysis is how the service users and therapists orient to a need for delicacy when utilising the terms "depressed" and "depression". This again suggests that unlike previous discursive findings, depression is not explicitly constructed and talked about.

9.3 Analysis - Service Users' and Therapists' Utilisation of the Terms "Depressed" and "Depression" During CBT Sessions:

9.3.1. Overview of Key Findings:

The first part of the analysis focuses on the utilisation of the term "depressed". The first strategy constructs "being depressed" in the third person and as a preferred response. This strategy was used to distance the service user from the disclosure of depression, orienting to a need for delicacy when utilising the term "depressed". The second strategy shows how explicit disclosures of "being depressed" are used to position the service user as unaccountable for their inefficiency at work and misunderstood by others. In both strategies "being depressed" was constructed as a transient state that temporarily impacts behaviour and was used to resist formulations that depression is a trait and part of their identity. The third strategy constructs depression as a known concept and the service users experience as an expected consequence of depression; this was used to accomplish empathy. Within the fourth strategy the service user labels them self as "having depression" in order to present their emotional distress as serious and resist the therapist's formulation that they are accountable for their distress and recovery. However, in the fifth strategy the service user actively resists the label of "depression" to position themselves as in control of their distress and recovery. In all of these strategies "depression" is constructed as permanent, deterministic, inevitable and an objective entity.

9.3.2. "Being Depressed" - Negotiating What "Depressed" and "Depression" Means For an Individual:

The first extract is an exchange between a service user and a therapist during their third CBT session. Extract one is a response to the service user's prior dialogue in which the service user discussed not wanting to meet friends because they feel "rubbish". The service user also discussed not wanting to disclose how they feel to their friends but

trying to "act normally" consequently makes them feel "fake". During extract one the service user and therapist negotiate what "depressed" and "depression" mean for an individual and the perceived implications a label of depression has. An interesting facet of extract one is the subtleness of the service user's disclosure that they are "depressed". It comes after probing from the therapist and is disclosed hesitantly as a preferred response. The therapist constructs depression as fixed and impacting on identity, whereas the service user rejects this premise and constructs depression as a transient state, separate from identity. Both the therapist and service user situates their rhetoric in the third person. This orients to a need for delicacy when utilising the terms depressed and depression, and allows the service user to distance them self from the disclosure.

Extract One – Service User SUB and Therapist T02:

1	**Therapist:**	So: if say: it's one of your: friends↓ (.) that's feeling:↓ (.)
2		that felt: down and they told you I (.) >same sort of thing<
3		uh: I go out an um (.) <it all feels fake to me> and I'm: (.)
4		putting on a brave face:↑ (.) but I actually feel (.)
5		completely: rubbish↓ (.) what meaning:↑ would you: put
6		with that (.) <if↑ (.) they: said that to you:↑>
7	**Service User:**	I would say (.) that they were depressed↓
8	**Therapist:**	And does: that hold any meaning:↑ (.) if someone has:↓
9		depression (.) does: that: say anything about them as a
10		person:: or↑
11	**Service User:**	No: just they're not happy with (.) life:↓ at the moment:↓

In the first part of extract one between lines 1-6, the therapist reformulates the service user's previous statements regarding their distress and composes it in the third person from the perspective of the service user's friend (line 1). This CA concept of reformulation is used to prompt the service user to disclose that they are depressed, without judging them self and it is also used to attribute meaning to the service users prior dialogue (Perakyla *et al* 2008). Composing the dialogue in the third person distances the service user from depression and allows the service user to view their situation from the outside. Composing the discourse from a friend's perspective (line 1), is used to encourage the service user to talk about their apprehension regarding disclosing depression to friends. When reformulating the service users distress the therapist orients to a need for delicacy (Pomerantz, 1984). This is conveyed through

frequent dispreferred responses (lines 1,2,3) and false starts (lines 1,2,3). (Pomerantz, 1984). The therapist also changes tense from present "feeling" to past "felt" (line 1-2). This conveys hesitation and constructs depression as a transient state rather than a trait possessed by the service user.

During the reformulation, the therapist avoids the terms "depressed" or "depression" and instead constructs depression through alternative terms (line 2 and 5). The therapist draws on the metaphors "down" (line 2) and "rubbish" (line 5) to convey distress. This discursive device is discussed in more detail in chapter eight. Avoiding the terms "depressed" and "depression" in this extract could be to ensure that the service user is the one to use the terms "depressed" or "depression". It also demonstrates that the therapist is orienting to a need for delicacy. At the end of the first discursive sequence, the therapist asks what the described emotional distress means (line 5). This is used to encourage a discloser of depression. The repetitive pronoun selection "you" (line 5-6) directs the discourse towards the service user and presents the dialogue as a question that requires a response (Potter, 1996).

The service user responds with a disclosure of depression (line 7). An interesting facet of this disclosure is that it comes after probing from the therapist and is disclosed hesitantly as a preferred response. The service user adopts the therapist's speech style; composing their rhetoric in the third person. This allows the service user to distance them self from the disclosure and subtly disclose that they are depressed. Placing this disclosure outside the individual allows the service user to protect their identity, as they are not referring to them self. This in turn presents the service user as hesitant about disclosing being depressed. The service user also accounts for the possibility that they might not be giving the preferred response by composing their disclosure as their opinion (line 7) (Potter, 1996). This is also an example of how the service user is attending to the perceived expert knowledge held by the therapist. All of the above suggests that a disclosure of being "depressed" is composed in a hesitant manner and the service user is orienting to a need for delicacy when utilising the term "depressed".

The therapist attends to the disclosure of being depressed (line 7), by probing for more information and enquiring about the implications this has on identity (line 8-10). The

therapist again composes their assertion in the third person; this time framing it more generally about "someone" (line 8). On line 9 the therapist utilises the term "depression" rather than the term used by the service user; "depressed" (line 7). This subtle lexicogrammatical preference impacts on how identity is constructed and understood. Utilising the term "depression" (line 9), constructs depression as something external which an individual possesses; "has depression" (line 8-9). However, the service user's sequence "they were depressed" (line 6) constructs depression as a transient state that is dependent on changeable context (Cornford *et al*, 2007; Fleischman, 1999). As well as the lexicogrammatical preference the therapist also insinuates that depression has implications regarding identity (line 9-10). This is used to gain a better understanding of the service user's reluctance to disclose how they feel to friends and invites a no response.

The service user explicitly resists the insinuation that depression impacts the type of person they are (line 11). This is firstly achieved through an explicit rejection of the therapist's assertion (line 11). The service user then reformulates being depressed as unhappiness (line 11). This constructs depression as non-pathological and a transient state dependent upon life events (line 11) (Cassell, 1976; Harvey, 2012). All of the above is used to reject the therapist's assertion that depression is a fixed trait that imparts on identity (Cornford *et al*, 2007). It also suggests that being depressed does not happen without a trigger and is therefore a legitimate response to life events. This rejects the insinuation that the service user is a fundamentally flawed individual and constructs "depression" as the opposite of happiness (De Shazer, 1997; Harvey, 2012).

9.3.3. "When I'm depressed" – Constructing Depression as the Cause of Atypical Behaviour:

Analogous to extract one the service user and therapist in extract two (A) and (B) construct depression as a transient state. However in contrast to extract one, where the service user subtly discloses that they are "depressed" following a probe from the therapist, in extract two (A) the service user explicitly states that they are depressed. This is used to position the service user as unaccountable for their performance at work and misunderstood by their boss. In extract two (A) and (B) the service user and therapist construct depression as: controlling, transient, an illness, a state that impacts the perception of the self and causes low mood. Extracts two (A) and (B) are service

user initiated and are exchanges between a service user and a therapist halfway through their CBT session. In the dialogue immediately prior to this extract the service user was discussing the negative appraisal they received from their boss; which stated they needed to "sort their attitude out" and they "needed a lot of support". The service user depicted this appraisal as inaccurate.

Extract Two (A) – Service User SUC-R2 and Therapist T03:

1	**Service User:**	I'm just giving you more reasons to think I can't do my job:
2	**Therapist:**	Mmmhmm
3	**Service User:**	Because:↑ when I'm depressed↓
4	**Therapist:**	Mmm
5	**Service User:**	>I can't convince anyone:↑ that I'm good at anything:↓
6		because I don't believe::↑ I'm good at anything:↓< (.) but
7		you know
8	**Therapist:**	So it's that vicious cycle=
9	**Service User:**	= I do know::↑ that I'm °good at° (.) (h)
10	**Therapist:**	yeah=
11	**Service User:**	=good: at things:: (.) >it's just I can't see<
12	**Therapist:**	yeah::
13	**Service User:**	you know (.) >see that when I'm ill<

In the first part of the extract the service user presents the idea that others, in particular their boss, perceive them as incapable of doing their job (line 1). This statement is constructed as self-blaming as the service user positions them self as accountable for this assumption (line 1). The service user also insinuates that they are adding to an already established argument (line 1). However, this argument is presented as an opinion rather than a fact (line 1), positioning the statement as potentially untrue. The service user composes this introductory statement as inviting a 'no' response from the therapist (Clayman and Heritage, 2002). However, the therapist does not reject this premise and instead responds with a continuer and signal of agreement (line 2) (Schegloff, 1981).

In the absence of a rebuttal from the therapist, the service user discloses being depressed

(line 3). The disclosure is presented as the explanation for their inefficiency at work. This is accomplished by inserting an explanatory phrase "because" (line 3) before the disclosure. This is similar to chapter eight where being ill was constructed as the explanation for the service user's potentially atypical behaviour. Constructing depression as the cause of inefficiency as opposed to the service user's ability, allows the service user to manage their accountability for work performance. Analogous to extract one the service user constructs being "depressed" as a transient state. This is achieved through the use of the term "when" (line 3). This allows the service user to construct depression as an explanation for their lack in proficiency as opposed to a lack of ability. The service user also constructs depression as controlling and impacting their perception of self (line 5), which allows the service user to position them self as passive and depression as the cause of work inefficiency.

The therapist attended to the service user's disclosure of being depressed with agreement and corroboration (line 8) and draws on the interpretive repertoire "vicious cycle"; a known idea that depicts an unpleasant situation caused by a sequence of reciprocal problems that intensify or aggravate each other to ultimately worsen the situation (Oxford Dictionary, 2016). This repertoire is a metaphor that depicts the cause and effect relationship between being "depressed", inefficiency at work and a negative self-perception (Beck 1967). Drawing on this metaphor allows the therapist to formulate depression as negative and enduring (line 8). As the therapist did not reject the service user's negative assertion about the self, the service user responds by insinuating their initial statement could be false. They suggest they are good at things but depression distorts their perception of self (line 9-11). This argument is situated as a factual statement (line 11) and emphasises that being "depressed" is not within the service user's control (Freesmith, 2007). This is used to emphasise the impact of depression on self-perception and subsequently positions the service user as unaccountable for work performance. The service user also constructs being depressed as an illness (line 13). This is again constructed as a transient state and as the explanation for their negative self-perception. This consequently situates the service user as passive in relation to their depression and ultimately not accountable for their behaviour (Harvey, 2012; Mintz, 1992; Warner, 1976). Constructing depression as an illness is used to position the service user as entitled to reasonable adjustments afforded to sick individuals (Lafrance, 2007).

Extract two (A), demonstrated how the service user discloses being depressed to position themselves as unaccountable for their inefficiency at work. The service user constructs depression as an illness and transient state that impacts their behaviour and perception of self. Extract two (B) comes directly after extract two (A) in the transcript. In extract two (B), the therapist adds meaning to the service users dialogue via a reformulation (Perakyla *et al* 2008). The therapist utilises the term "depressed" and "depression" and provides an explanatory framework for the service user's distress. Although the use of the term "depressed" is more explicit in extract two compared to extract one, when utilising the terms "depressed" and "depression" the therapist still appears to orient to a need for delicacy and composes their dialogue in a hesitant manner.

Extract Two (B) – Service User SUC-R2 and Therapist T03:

14	**Therapist:**	and when you're: depressed: as we've said before↑ you
15		look at the model of depression::
16	**Service User:**	yeah
17	**Therapist:**	you get stuck in: <or you know not you but uh: a person:>
18	**Service User:**	yeah
19	**Therapist:**	gets stuck in (.) that cycle where↑: they have the negative:
20		beliefs: about themselves::
21	**Service User:**	yeah
22	**Therapist:**	and then they believe:: that and then (.) leads:: to kind of:
23		feeling↑ more: low in mood::↑
24	**Service User:**	yeah::

Akin to the service user in extract two (A) the therapist constructs the service user as depressed and constructs being depressed as a transient state (line 14). The therapist personalises the formulation of being "depressed" to the service user through the pronoun choice "your" (line 14). However, they then shift pronoun choice to "we've" (line 14) when discussing the therapeutic work conducted in the past. This constructs the therapy as collaborative and a joint process. The use of the phrase "said before" (line 14) insinuates that the therapist and service user have previously discussed being

"depressed" and depicts what they are about to say as a known concept to the service user. All of this discursive work is building to the therapist's main point regarding the "model of depression" (line 14-15). The "model of depression" insinuates that the service user's experience is typical of depression and presents their distress as an expected consequence (line 15). The lexicogrammatical change between the terms "depressed" and "depression" is of interest on lines 14-15. The term "depressed" is presented as a transient state that is personal to the service user; whereas the term "depression" is presented as a known concept or noun with its own aetiology and symptomology. It is also presented as more formal, impersonal and tangible. The service user agrees with the therapist's formulation and does not appear deterred by the use of the term depression (line 16).

After introducing the "model of depression" the therapist distances the service user from their construction of depression. This is accomplished by correcting their initial statement with a self-repair (changing the pronoun selection from "you" to "a person" line 17) (Levinson, 1983). The therapist also composes this sequence in a hesitant manner and orients to a need for delicacy when talking about depression. This is accomplished via false starts (line 17) and a disclaimer (line 17) (Billig *et al* 1988; Pomerantz, 1984). This suggests that labelling someone as having depression is potentially negative and the therapist is actively accounting for this during their dialogue (Hewitt and Stokes, 1975).

After distancing the service user from the construction of depression, the therapist goes on to construct depression, as a cycle that causes low mood and impacts the perception of self (lines 19-23). This validates the service user's conceptualisation of depression depicted in extract two (A). When constructing depression the therapist utilises the same terminology as the service user in extract two (A). This aligns the description of depression to the service user without explicitly labelling them as having depression. However, the therapist repeatedly uses the pronoun "they" (line 19 and 22) which generalises the construction and distances the service user from the depiction of depression. This again highlights the need for delicacy when constructing depression in therapeutic interaction. When constructing depression, the therapist utilises the metaphor "stuck in that cycle" (line 19) to depict the model of depression. This metaphor discernibly depicts depression as hard to resolve, and having a cause and effect relationship with the perception of the self. Depression is also constructed as something that distorts the perception of the self and ultimately results in low mood

(line 22-23). The negative perception of self is presented as a belief of the individual with depression (lines 20-22). This orients to the premise that the negative perception is potentially untrue and unwarranted. Constructing depression as controlling, hard to resist and impacting mood and perception, positions the service user as passive and unaccountable. This is because depression is constructed as the cause of the service user's negative self-beliefs, lack of proficiency at work and low mood.

9.3.4. "What is it Depression" Negotiating what Depression is and its Permanency:

The previous sections of analysis focused on how the term "depressed" is utilised and constructed in therapeutic interactions. The next sections of analysis will focus on how the term "depression" is constructed and utilised. Extract three is an exchange between a service user and therapist at the end of their fifth CBT session. Earlier in the session the therapist suggested that the service user is feeling "shit" because of their "negative perception of things" and that the service user needs to change the way they think about their failing to recover. In extract three the service user responds to the therapist's formulation. The service user resists the therapist's formulation and the possibility that they have some control over their distress. This is the only time during the therapy session that the service user explicitly used the term depression. The service user utilises the term "depression" and constructs them self as having depression in order to present their emotional distress as more serious than the therapist suggested and therefore reformulates the therapists dialogue around their distress into a serious and permanent condition (Perakyla *et al* 2008). The service user constructs depression as permanent, deterministic, inevitable and an objective entity and constructs depression as the result of genetic or chemical programming. Constructing depression as a result of biology positions the service user as passive and depression as a permanent state that is hard to recover from. All of the above works to resist the therapist's formulation that the service user is in some way accountable for their distress and recovery. How the service user utilises the term depression is of interest in this section of analysis.

Extract three – Service User SUD-R1 and Therapist T04:

1	**Service User:**	umm (hhh) (2.0) god: (.hhh) (.) n then I just start thinking
2		>oh my god what's my life going to be like< am I (.) am I (.)
3		gunna be constantly in n out of like: this (.) >what is it
4		depression:< or I don't even know if (1.0) if its depression
5		(.) depression: sound:: (.) <really: (.) full↑ on>

6	**Therapist:**	Yeah
7 8 9	**Service User:**	(.hhh) (2.0) Um (1.0) am I a person: ↑ who just programmed: or (.) chemically: somehow my (.hhh) make up (1.0) my (.) gens: or whatever↓
10	**Therapist:**	Mm
11 12 13	**Service User:**	Are::: (.) making (.) me always↑ on the edge of (.) this: (1.0) depression: ↑ (.) thing (.) >that's going on↑< (.) how can I get rid of that↑ (0.5) >can I get rid of that↑<

In the first part of the extract the service user negotiates whether they have depression and what depression is (line 2-5). The service user constructs the possibility that they have depression in a hesitant manner via dispreferred responses (line 1-3), frequent pauses (lines 1-3), false starts (line 2) and through a series of rhetorical questions "what is it depression" (line 3-4). These rhetorical questions are non-committal and offered as a possibility that requires validation. After proposing they have depression, the service user retracts their claim (line 3-4). All of the above situates claiming to have depression as a serious accusation and suggests the service user is orienting to the need for delicacy when positioning them self as having depression (Pomerantz, 1984). This could be because the service user is accounting for their perceived lack of knowledge compared to the therapist or because the term depression is associated with stigma. Although the service user orients to a need for delicacy, they nonetheless utilise the term "depression" three times between lines 4-5, asserting the notion that they have depression. Negotiating having depression is used to tentatively establish the service user's distress as pathological rather than a normal reaction or emotion (Harvey, 2012). This allows the service user to manage accountability, and resist the therapist's formulation presented earlier in the CBT session; that their "negative perception of things" is causing them distress. The therapist does not dispute the service user's proposal that they have depression and instead responds with a continuer (line 6). This is interesting because previously the therapist challenged the service user and suggested that they are accountable for their distress.

Whilst negotiating the possibility they have depression, the service user simultaneously constructs depression as permanent, deterministic, inevitable and an objective entity.

The service user constructs depression as an objective entity by situating depression as a noun, through the use of "it" and "this" (line 3-4). This enables the service user to construct depression as a distinct entity rather than a reaction or emotion. This consequently positions the service user as passive and allows the service user to resist the therapist's formulation that they have control over their distress. The service user also constructs depression as inevitable because it is the result of genetics and chemical programming (line 8-9). Utilising biological terminology such as "programmed" "chemically" "make up" and "genes" (line 8-9), situates depression as genetically predisposed and the service user as a passive victim of biology (Pitcher, 2013). This again constructs emotional distress as pathological, allowing the service user to manage blame, because the service user cannot be responsible for their genetics. In addition to constructing depression as inevitable, the service user constructs depression as a fixed experience with little prospect of resolution (Harvey, 2012). The service user constructs the permanency of depression through the use of terms such as "life" (line 2), "constantly" (line 3), "programmed" (line 8), and "always" (line 11). Emphasising the permanency and long-term impact of depression is used to accomplish a lack of control and manage accountability for their distress (Drew *et al*, 1999). Constructing depression as permanent, deterministic, inevitable and an objective entity all works to resist the therapist's formulation, that the service user has control over their distress.

At the end of extract three the service user constructs depression as hard to overcome because depression is a genetic predisposition (line 12-13). Positioning recovery as difficult and potentially unfeasible, allows the service user to position them self as a passive victim with no control over their emotional distress. Constructing depression as something that cannot be controlled or changed is again used to resist the therapist's formulation of depression, that they have control over their distress. Akin to lines 2-5 the service user constructs their recovery as a rhetorical question and appeal for help (line 12-13). Composing the rhetoric as a question allows the service user to gain validation from the therapist and account for the therapist's perceived expert knowledge.

9.3.5. "Depression's not me" – Resisting a Label of Depression:

Analogous to extract three, the service user in this extract constructs depression as an objective entity, serious, pathological and permanent. However in contrast to extract three, where the service user constructs depression in this way to position themselves as a victim of biology with a lack of control, in extract four the service user actively

resists the label of depression. Extract four is an exchange between a service user and therapist at the beginning of their third CBT session. Earlier in the therapy session the therapist recapped what was done in the last session and asked the service user for feedback on STOPP; a CBT tool used to help prevent ruminating. (see appendix 6). The service user responded by stating that STOPP helped but they were still having negative thoughts and cannot sleep at night because of ruminating. In extract four the service user resists the therapist's formulation that their emotional distress could be due to depression and in turn situates them self as in control of their recovery and distress. Whilst rejecting the premise that they have depression the service user constructs depression as: controlling, an objective entity, part of an individual's identity, permanent, biological in origin and negative. How depression is constructed and resisted by the service user will be discursively examined below.

Extract Four – Service User SUE-R2 and Therapist T04:

1	**Therapist:**	ok (1.52) umm:: n did you read through: the::↑ (.)
2		information (.) we give you on: depression↑
3	**Service User:**	<a little:↑ bit:>
4	**Therapist:**	yeah↑
5	**Service User:**	yeah: (1.01) mm::
6	**Therapist:**	ok
7	**Service User:**	>I did fold it up put it in my bag< (h) n then I went to
8		[name of place] n forgot about it:
9	**Therapist:**	Ok (h)
10	**Service User:**	N did a bit of a road: trip:↑
11	**Therapist:**	Ok:↑
12	**Service User:**	**>**Well I refuse to believe::< (In) I'm very like that↓ (.) I'm
13		sorry (.) I refuse to believe (.) to like (.) I I've dragged
14		myself here:↑
15	**Therapist:**	Ok
16	**Service User:**	So↑ (.) if I read something↑ that's (1.37) I just know:↑ I
17		need to make myself: feel better but=
18	**Therapist:**	=Ok what what is it about=

Service User: =>If it's if it's writing on depression< (.) I just think <no:: it's not me↓>

Therapist: What so↑=

Service User: =Denial-

Therapist: Depressions:↑ not you↑

Service User: Yeah↓- (1.0) <cause I've come off my medication::↑>

Therapist: Ok

Service User: °Although I believe that:°

Therapist: Yeah=

Service User: =Yeah

Therapist: Ok:

Service User: >Cause I read the STOPP leaflet↑<

Therapist: Yeah=

Service User: =>But the depression one< (.)°I didn't really: read°

Therapist: Yeah so what was the difference between the STOPP n the depression one=

Service User: =I think just the word: depression::↑ (.) I just (.) don't wanna (.) feel that it's there:: (.) do you know: what mean↑

Therapist: =Ok

Service User: I don't know why::=

Therapist: =>The main reason I give you that that leaflet was: because of the STOPP anyway: ↓<

Service User: Right:↑

Therapist: Yeah (1.02) umm:: n I mean we're not (.) we're not trying to label↑:: you=

Service User: =Yeah yeah I know I know=

Therapist: =Or anything like that anyway↑:: (.) um:: (3.05) ok (.)°ok°

Service User: >There's loads of positives↓ on a positive note::↑< (.) fifty one↓ (.) within fifty one days::↓ I'll get my settlement: through: (.) >and I can buy my own house::↑<

49 **Therapist:** Yeah::

In the first part of the extract the therapist introduces the term depression (line 1-2). Here the therapist hesitantly proposes that the service user's distress or ruminating could be caused by depression. Although the introduction of the term depression is explicit, the therapist starts the proposal with a dispreferred response, false start and frequent pauses (line 1). This suggests that the therapist is orienting to a need for delicacy when situating distress as a result of depression (Pomerantz, 1984). The service user initially attends to the therapist's use of the term "depression" and proposal that depression is the cause of their distress, with a hesitant noncommittal agreement (line 3) and delicately builds to a rebuttal of the therapist's formulation (line 3-11). This rebuttal culminates on line 12 where the service user explicitly rejects the therapist's formulation that they have depression (line 12-14) and constructs having depression as a "belief" rather than a fact. This rebuttal is followed by an apology (line 13) which indicates the rebuttal could be problematic. The service user then positions them self as having control over their distress and recovery, by constructing coming to therapy as a choice (13-14). In this extract therapy is presented as evidence of not having depression. This in turn suggests that having "depression" signifies a lack of control and inability to function or come to therapy.

The service user then offers an explanation as to why they have not read the information on depression (line 16). However, the service user corrects what they are about to say with a self-repair (Levinson, 1983), and instead downplays their distress by constructing distress as non-pathological and lacking severity (line 16-17). The service user also positions them self as accountable for their distress and recovery (line 17). This consequently constructs depression as serious and controlling, and individuals with a diagnosis of depression as passive victims with no control. The therapist attends to the service user's rebuttal with an explicit question to ascertain more information about why the service user refutes the proposal of depression (line 18). The service user continues to more explicitly reject the premise that they have depression and justify why they did not read the information on depression (line 19-20). In doing this the service user constructs their identity as a non-depressed individual (line 19-20). The construction of identity is accomplished through the discursive device of renouncing what type of person they are; "no it's not me" (line 19-20). The use of "no it's not me" subsequently constructs depression as a trait that the service user does not possess and depicts depression as an objective entity that intrudes on the self. When constructing

identity, the service user utilises the term “depression” for the first time (line 19). The term “depression” is used here to emphasise the argument that depression is not part of their identity and rejects the therapist’s formulation that depression is responsible for the service user’s distress.

The therapist questions the service user’s construction of their identity as a non-depressed individual (line 21). The service user attends to this questioning by constructing them self as in denial (line 22). The term “denial” works to accomplish two things. Firstly, it reaffirms the service user’s previous statement that they believe they do not have depression. However, it also simultaneously suggests that there is a possibility the service user may have depression. The therapist then reformulates the service user’s rhetoric to “depressions not you” (line 23). This is used to question the service user’s construction of their identity as a non- depressed individual and enquire for more information. The service user affirms that, “depression is not them” firstly with a signal of agreement (line 24) and secondly by presenting supporting evidence. Coming off medication is presented as the supporting evidence (line 24). This constructs depression as biological in origin and suggests medication is the only treatment for depression. Constructing themselves as not having depression because they no longer need medication, is similar to previous discursive literature that found individuals who do not use antidepressants were constructed as not suffering from ‘real’ depression; ‘alternative medicine is for alternative depression’ (Oliphant, 2009). This same discursive device is utilised by the service user to construct them self as not having depression. The therapist does not question or object to this construction instead the therapist attends to the service user’s construction with a hesitant signal of agreement (line 25).

After positioning them self as a non-depressed individual, the service user constructs the term “depression” as problematic (line 35). During this construction, depression is constructed as an objective entity that enters or resides within the individual (line 36). This depicts depression as permanent and hard to ignore, which in turn acknowledges depression could be present. (line 35-36). After the term “depression” has been constructed as problematic, the therapist distances them self from their original proposal and retracts their original statement regarding their reasoning for giving the service user information on depression (line 39-40). At the start of the extract the therapist presented the information on depression as important (line 1-2). However, the therapist now emphasises the STOPP information as the most important aspect.

Framing STOPP as "the main reason" (39), downplays the previous argument. The service user attends to this with a tentative agreement (line 41), questioning the authenticity of the therapist's formulation. This questioning prompts the therapist to defend their statement further by explicitly rejecting the premise that they are labelling the service user as depressed (line 42-43). The therapist orients to labelling as negative (line 35-36). This is in response to the service user's distress and unease regarding the term "depression". The service user responds to this denial of labelling with a strong signal of agreement (line 44) and changes the focus of discussion by listing positive aspects of their life (line 46). Utilising the term "positive" consequently constructs depression as a negative and the consequence of negative life events, rather than internal traits.

9.4 Discussion:

9.4.1. Overview of Results:

This chapter examined the rare occasions that therapists and service users utilised the terms "depressed" and "depression", and how service users and therapists discursively construct depression during therapeutic interactions. Being "depressed" was constructed as controlling, a transient state separate from identity, an illness, and a state that impacts the perception of the self and causes low mood. It was also constructed as a result of social circumstance. This construction of depression was used to marginalise the role of the service user in their illness experience and consequently position them as unaccountable for their distress, behaviour or time off work. The term "depression" was constructed as controlling, serious, permanent, biological in origin and an objective entity. It was also constructed as a known concept or noun and the result of a biological abnormality. This construction was used to position the service user as a passive victim of biology and therefore unaccountable for their distress and recovery. What is noteworthy about this section of analysis was that although the service user and therapist chose to utilise the terms "depressed" and "depression" they both orient to a need for delicacy when utilising the terms. Furthermore, the terms "depressed" and "depression" where often utilised to emphasise distress or resist formulations that the service user is accountable for their distress and recovery.

9.4.2. Implications for Literature:

Overall this analysis provides a unique perspective regarding the construction of depression because to date no discursive research has looked at how service users and therapists jointly construct depression during therapeutic interactions. Previous literature has analysed this separately and retrospectively via interview. This is the first analysis to look at how depression is constructed in a UK therapeutic setting. In addition to this the current analysis has identified four novel findings that contradict or expand previous literature regarding the construction of depression.

Firstly, previous literature suggests that lay individuals and mental health professionals explicitly talk about depression. However, the current analysis found that service users and therapists rarely utilise the terms "depressed" and "depression" and when they do they orient to a need for delicacy. This finding was present in all extracts, however it was the most prominent in extracts one and four. In extract one the service user and therapist composes their dialogue in the third person to distance the service user from a disclosure of depression. In extract four the service user actively resists a label of depression and the therapist distances themselves from accusations of labelling. Furthermore, in this analysis being labelled as depressed or having depression is oriented to as negative. This finding is divergent to previous discursive literature that found that labelling is constructed as a positive because it brought relief, validation and legitimisation (Lafrance, 2007; Wisdom and Green, 2004; Issakainen, 2014). In the current analysis a label of depression is constructed as negative, deterministic and permanent.

Secondly, because previous literature suggested the use of the terms "depressed" and "depression" was explicit, it neglected to examine why the terms are utilised and what utilising these terms accomplishes. A novel contribution of the current analysis is that it offered an examination of what utilising the terms "depressed" and "depression" accomplishes in therapeutic interactions, to gain a better understanding of why the terms are utilised. On the rare occasions the terms "depressed" and "depression" were utilised they were used to emphasise distress, construct distress as serious, demonstrate a lack of control over behaviour and resist accusations that the service user is accountable for their distress and recovery. Furthermore, the terms were often utilised after probing from the therapist or when resisting the therapist's formulations (resistance in therapy was discussed in more detail in chapter seven). Therefore, the

terms “depressed” and “depression” are often utilised as a preferred response, to end a confrontation or to emphasise the speaker’s argument.

Thirdly the current analysis around the construction of depression adds to previous CA research regarding psychotherapy. The analysis identified similar discursive devices often utilised in therapy, such as formulations and reformulations (Perakyla *et al* 2008). Previous CA research has found that the therapist utilises the device reformulation to attribute meaning to service user dialogue. This was convergent in extracts one and two B. However in extract three the service user utilises this device to reformulate the therapist’s construction and attribution of distress. In extract three the service user reformulates distress into depression to convey permanency and seriousness. This diverges from previous research that frequently found it was a device unitised by therapists to accomplish therapeutic work (Perakyla *et al* 2008); here it was the service user who utilised this device.

Lastly, a key finding from linguistic examination found that individuals frequently situated their accounts of depression around two reoccurring constructs: “I am depressed” and “I have depression”. However non-discursive examinations could not offer suggestions about what constructing illness experience in these ways accomplishes. The current analysis found that being “depressed” was constructed as: controlling, a transient state separate from identity, an illness, and a state that impacts the perception of the self and causes low mood. It was also constructed as a result of social circumstance. Constructing “being depressed” in this way was used to marginalise the role of the service user in their illness experience and consequently position them as unaccountable for their distress, behaviour or time off work. Service users also resisted accusations that being depressed impacts their identity. Conversely the term “depression” was constructed as controlling, serious, permanent, biological in origin and an objective entity. It was also depicted as a known concept or noun and the result of a biological abnormality. It was constructed as impacting their perception of self and part of their genetic makeup. This constructed depression as hard to recover from, and the service user as destined to have depression regardless of social circumstance. This construction of depression was used to position the service user as a passive victim of biology and therefore unaccountable for their distress and recovery. This finding implies that the terms “depressed” and “depression” have very different meanings and the lexicogrammatical differences between the terms have different implications regarding: aetiology, prognosis, trajectory and identity. Although this is a novel finding it has

limitations regarding generalizability because the dialogue is taken from a specific context (CBT sessions) and from a specific sample (trainee therapists). Therefore future research should explore if this finding is consistent across therapeutic disciplines and across therapist experience levels. Doing this could also aid clinical practice.

9.4.3. Implications for Clinical Practice:

Chapter eight demonstrated that future research needs to focus on what the term "depression" means to lay individuals and mental health professionals because it suggested that there is uncertainty around the concept of depression. This was partly attributed to the lack of a universal definition of depression and the changing conceptualisation of depression throughout history. The current analytic chapter supports this claim as the hesitant use of the terms "depressed" and "depression" suggested unease around the use of the terms. This uncertainty could have an impact of rapport and treatment outcome, and therefore future research needs to explore what the terms "depressed" and "depression" mean.

One of the most novel findings of this analysis was that the terms "depressed" and "depression" are used to accomplish very different and specific discursive actions. The lexicogrammatical differences between the terms "depressed" and "depression" were found to have implications regarding how aetiology, prognosis, trajectory and identity are constructed. Therefore, clinicians need to be aware of these implications when utilising the terms and need to understand what these terms mean to service users. A lack of awareness could impact the service users' understanding of treatment, prognosis and aetiology and reduce rapport. One way to increase therapeutic alignment and accomplish rapport would be to have an initial discussion with service users at the start of therapeutic interactions. This discussion should focus on the service users' understanding of the "terms "depressed" and "depression" to identify the implications the use of these terms would have on aetiology, recovery and prognosis. In addition to this the use of the terms "depressed" and "depression", created unease and resistance between the therapist and service user. This was most noteworthy in extract four where the service user actively resisted a label of depression because they viewed depression as controlling and biological in origin. This finding has implications for clinical practice because not understanding what the term "depression" means to an individual could result in damaged rapport or accidently condemning individuals' identity rather than validating distress.

An understanding of why the terms "depressed" and "depression" are utilised could aid clinical practice because it would provide the clinician with a better understanding of the service users' objectives. On the rare occasions the terms "depressed" and "depression" were utilised in this analysis they were used to emphasise distress, construct distress as serious, demonstrate a lack of control over behaviour and resist accusations that the service user is accountable for their distress and recovery. In this instance displaying empathy and understanding after a disclosure of depression could aid rapport and ensure the service user feels understood.

9.4.4. Conclusion:

This is the first discursive analytical study to examine how service users and therapists jointly construct depression and attend to these constructions during therapeutic interactions. By examining the rare occasions therapists and service users utilised the terms "depressed" and "depression" it was highlighted that service users and therapists both oriented to a need for delicacy. This demonstrates unease and depicts the label of depression as potentially negative. The most novel finding from this section of analysis was that the terms "depressed" and "depression" were used to accomplish very different and specific discursive actions. The lexicogrammatical differences between the terms "depressed" and "depression" had implications regarding: aetiology, prognosis, trajectory and identity. Future research needs to focus on what the term "depression" means and how depression is constructed during training. Additionally in order to accomplish rapport and therapeutic alliance, clinicians need to be aware that the terms "depressed" and "depression" have different meanings and different implications regarding aetiology, prognosis, trajectory and identity.

Chapter Ten - Identity Construction in Accounts for Depression During Cognitive Behavioural Therapy (CBT) Sessions:

10.1 Overview:

The previous analysis chapters discursively examined how depression is constructed in Cognitive Behavioural Therapy (CBT) sessions. It was found that the terms depressed and depression are used infrequently during therapy. Chapter eight highlighted how service users and therapists utilise alternative terms when constructing depression. Chapter nine examined the deviant cases where the terms are utilised and found that the terms "depressed" and "depression" are utilised hesitantly and have different uses. How the self is constructed is of importance to the CBT paradigm because the cognitive model of depression suggests that negative thoughts, which are postulated as the cause of depression, could be characterised in terms of the cognitive triad; negative beliefs about the self, world and future (Williams, 1984; Young and Beck, 2001). The current chapter will build on previous analytic chapters which found conceptualisations of depression are used to construct identity. The current chapter will explore identity construction in more detail by examining how individuals construct identities during CBT sessions for depression. It will focus specifically on how service users construct themselves, what these constructions accomplish and how they are attended to during therapeutic interactions.

10.2 Introduction:

Depression can be understood as both a social identity (being a sufferer of depression) and an individual identity (being depressed). Understanding how people negotiate group identity has been a focus of social psychology research for over 30 years. However, this research focuses on social groups without mental illness and therefore fails to investigate how individuals with depression negotiate and construct themselves and their identities (Cruwys and Gunaseelan, 2016). The studies that do exist suggest that individuals often construct depression as self-defining (Karp, 1994), and a weakness of character (Cornford *et al* 2007; Boardman *et al* 2011). Other studies demonstrate that individuals construct depression as the result of a biological deficiency (Lebowitz *et al* 2013; Kvaale *et al* 2013) and therefore part of whom they are (Howard, 2008). However, in chapter nine it was demonstrated that individuals often constructed depression as a result of biological or genetic deficiency to manage accountability for depression, and situate recovery as out of their control.

Identity and the self are central features of the cognitive model of depression; which suggests an individual's affect and behaviour are determined by the way an individual perceives and structures the world (their thoughts) (Weishaar and Beck, 1986). Beck suggested that these thoughts could be characterised in terms of the cognitive triad; negative beliefs about the self, world and future (Williams, 1984; Young and Beck, 2001). However, from a discursive psychology perspective, how individuals situate themselves (and others) within talk is central (Frosh *et al* 2003). Discursive psychology defines identity as a discursive action accomplished through dialogue, because drawing on specific identities achieves action orientation (Abell and Stokoe, 2001). Identity is seen as fluid and continually constructed and negotiated in social contexts (McInnes and Corlett, 2012; Potter and Wetherell, 1987). Discursive psychology suggests that multiple identities or facets of identity can be simultaneously constructed (Bucholtz and Hall, 2010; Frosh, 2002; Spencer and Taylor, 2004). Furthermore, group identities such as gender, ethnicity and mental health, are constructed via language (McInnes and Corlett, 2012). This highlights the relevance of examining how the self is constructed through the lens of depression during CBT sessions. Although there is a large body of discursive research regarding identity, to date no discursive studies have looked at how service users construct the self during CBT sessions for depression. Instead previous literature is divided into two themes; how identity is constructed during psychotherapy and how individuals with a diagnosis of depression construct identity outside of therapeutic interactions.

One aspect that has been explored in several studies regarding identity construction in psychotherapy is subject positioning; how speakers construct themselves and others in discourse. Discursive analyses are interested in when and how identities are invoked and constructed in conversation (Abell and Stokoe, 2001). A number of discourse analytic studies focused on the flexibility with which service users employed a diverse range of subject positions during psychotherapy (Diorinou and Tseliou, 2014; Karatza and Avdi, 2011). Another group of studies examined the negotiation of agency in therapeutic interactions by focusing on subject positions that accomplish control (Ayashiro, 2016). For example, Avdi (2005) demonstrates how, in systemic therapy with a child diagnosed with autism, medical discourse positioned the child as lacking agency. During therapy this was gradually shifted to position the child as competent and having agency over their behaviour. These studies postulated that subject positions that accomplish control are associated with psychological wellbeing (Avdi, 2005; Guilfoyle, 2002). For example, Burck *et al* (1998) identified shifts in parents' constructions of

themselves from a repertoire of 'being out of control' to 'being in charge'. The majority of this research examined identity construction in psychotherapy irrespective of the psychological difficulty. It does not examine how service users with depression construct their identities. Furthermore, most of this literature examined systemic or psychoanalytic therapy sessions. To date no research has examined how identity has been constructed during CBT sessions.

The second area of research focuses on depression and identity outside of therapeutic interactions. These studies found that individuals diagnosed with depression often construct a lost sense of identity (Stoppard, 2000). Another prominent feature was the construction of two identities: the depressed and non-depressed self (Bennet *et al* 2003; Lafrance and Stoppard, 2006). Constructing an alternative identity was used to manage accountability for depression. This was accomplished by situating the ''depressed self'' as flawed deviant and unstable, and the "non-depressed" self as the ''authentic self" (Bennet *et al* 2003). Constructing an alternative identity was used to emphasise ''normality'' and position the self as approachable. Being perceived as ''normal'' was postulated as the opposite of depression, and a barrier to future difficulties (Bennet *et al* 2003). Constructing two identities was also found in recovery discourse. After recovery, individuals constructed themselves as fundamentally different from the person they were before depression (Lafrance and Stoppard, 2006). Individuals depicted their former "depressed" identity as unsuitable, and their recovered self as disengaged from the "depressed" self (Lafrance and Stoppard, 2006). This helped situate recovered individuals as "normal" and their experiences within "normal" range. It was also used to resist claims of being inherently flawed and depression as inevitable (Wilson and McLuckie, 2002; Pitcher, 2013).

10.2.1. Research Aims:

Previous discursive literature highlights how individuals who previously had an episode of depression construct identity. However, these studies were conducted retrospectively via interview. None of the studies examined how individuals currently seeking help for depression constructed identity during therapeutic interactions. In addition to previous discursive literature, chapters eight and nine demonstrated that future research needed to focus on what the term "depression" means to lay individuals and mental health professionals. This was because these analyses demonstrated complexities around the concept of depression and that the terms had different implications regarding aetiology,

prognosis, trajectory and identity. The current analytic chapter builds on the previous chapter findings by providing an understanding of how the self and identities are constructed during CBT sessions for depression. Therefore, the aim of the current analysis is to discursively examine how service users with depression construct the self during CBT sessions, what the different constructions of self accomplish and how they are attended to within therapeutic interactions.

10.3 Analysis:

10.3.1. Overview of Key Findings:

In the vast majority of CBT sessions service users constructed various versions of self-identity. The analysis identified five key discursive strategies drawn upon by service users to construct themselves and their identities: (1) the negative construction of the self, (2) constructing identity as altered by depression and depicting a loss of self, (3) the notion of a true self and false self, (4) constructing the self as blameworthy for depression and (5) constructing depression as invading the self.

10.3.2. *Strategy One: "I'm Just A Bit Sad Sometimes" - The Negative Construction of the Self:*

It is a well-established notion that individuals diagnosed with depression often have negative outlooks (Beck, 1967; Rude *et al* 2004) and have a tendency to engage in negative verbal behaviour (Hinchliffe *et al* 1971). In extract one the service user constructs their self negatively, as unlikable, attention seeking and wasting the therapist's time. The negative construction of self is used here to downplay distress and position the service user as undeserving of therapeutic intervention. Extract one is taken from the service user and therapist's fifth session. In the dialogue prior to this extract the service user and therapist discussed the service user's "main concerns", such as missing a session and being an attention seeker. Immediately prior to the extract the therapist challenged the service user's claim that "the therapist doesn't like them" and asked if this were true why it would matter. Extract one is the service user's response to this challenge.

Extract One Service User SUF-R1 and Therapist T04:

1	**Service User:**	**>**[*therapist*] wouldn't be doing his job if he didn't want to
2		help people< (1.50) so: (2.20) but he doesn't like everybody
3		he helps:: (2.20) can you see where this is going↑ (h)
4	**Therapist:**	Ok umm: (1.50) so: again does it matter↑ (2.20) if you're:
5		getting something out of this:↓ (8.20)
6	**Service User:**	**°**Kind of° (1.20) Yeah:
7	**Therapist:**	it does↑
8	**Service User:**	yeah:
9	**Therapist:**	ok ok (.) so ok umm: (5.20) ok (.) so: let's combine that with
10		the second one then↑ so: you're attention seeking↓
11	**Service User:**	yeah::
12	**Therapist:**	so: (.) how are you attention seeking↑ (1.50)
13	**Service User:**	because the the the problems are or whatever I have is (.)
14		not (.) as (.) bad (.) as what people do so: surely somebody
15		could:
16	**Therapist:**	>how do you know that<
17	**Service User:**	because people have gone through bigger crap that's worse:
18		than mine↑
19	**Therapist:**	like what who
20	**Service User:**	people↑ in the world (h) other people
21	**Therapist:**	right ok
22	**Service User:**	**>**have gone through hardship n n what have you↑ n they
23		could probably do with the services better than I could<
24	**Therapist:**	right::
25	**Service User:**	I'm just a bit sad sometimes
26	**Therapist:**	ok so so does: that not make my job a bit easier::↑
27	**Service User:**	Does it↑
28	**Therapist:**	Does it↑

29 **Service User:** I don't know↑ does it it's your job (h)

Here the service user constructs the self negatively. This is accomplished in three ways; constructing the self as potentially disliked by the therapist, constructing the self as attention seeking and constructing the self as wasting time and resources. The negative constructions of self are used by the service user to downplay distress and simultaneously situate them self as both requiring help and being undeserving of therapeutic intervention. However, the therapist attends to the negative construction of self as evidence of depression or *negative thoughts generated by dysfunctional beliefs;* and attempts to challenge the service user's negative constructions, by utilising the CBT strategy *Testing NAT's* (lines 4, 9-10, 12, 16). The implementations of CBT strategies were discussed in more detail in chapter seven.

Between lines 1-6 the service user orients to the possibility that the therapist might not like them. This is firstly accomplished by positioning the therapist as a good person and as someone who wants to help people (line 2). The service user draws on the therapist's job as evidence to support their claim (line 1). However, the service user concurrently suggests that the therapist does not like everybody and insinuates that the therapist might not like the service user, because they are just doing their job (line 2-3). Positioning the therapist as a good person is used to resist a potential counterclaim that the therapist might not like many people (Edwards and Potter, 1992). All of the above orients to the possibility that they are disliked by the therapist and creates a negative construction of the self. The therapist attends to this insinuation with a question. By asking if it matters if 'you're getting something out of it' (line 4-5), the therapist orients to the service user as suggesting they might not like them. Questioning the assumptions importance and emphasising the importance of therapeutic outcomes (line 4), orients to the 'problem' as an internal matter of perspective (the service user caring about whether or not the therapist likes them) rather than an external interpersonal problem (whether or not the therapist actually liked them). However, this response does not challenge the assertion that the service user is un-liked instead it undermines its importance in a therapeutic setting. However, the service user response emphasises that being liked is important to them (line 6 and 8).

When the service user does not respond with the preferred response, the therapist refers back to an assertion the service user made earlier in the therapy session "So you're attention seeking" (line 10) and asks the service user to justify this assertion (line

12). To do this the service user situates others as worse off and claims their distress is not as bad as others (line 13-15). This situates the service user as undeserving of therapeutic intervention and downplays their distress. Situating the self as potentially un-liked and attention seeking creates a negative construction of the self during therapeutic interactions. This is used by the service user to simultaneously position them self as, requiring help but not as much help as others, who are worse off or more depressed than them.

The therapist attempts to challenge the service user's negative construction of self by questioning the authenticity of their claim that they are attention seeking and others are more deserving of help (line 16) (Potter, 1996). The service user defends their argument by stating that others have had more negative experiences (line 17). The service user's use of maximisations and explicit language such as "bigger crap" and "worse" elicit emotion and are used to emphasise the service user's point (Freesmith, 2007). This again downplays the service user's distress. The therapist challenges the service user's argument by undermining the authenticity of the service user's claim, by asking for more detail (line 19). The service user responds with a generalisation "people in the world (H) other people" (line 20) (Speer, 2005). The generalisation and laugher demonstrates that the service user's argument might be flawed. However, the service user continues to provide evidence that they are attention seeking and that others are worse off by situating them self as wasting recourses that others need (line 22-23). This again constructs the self negatively and supports their argument that they are attention seeking. It also creates a sense of unworthiness and downplays the service user's distress. The therapist does not challenge the service user's construction. They concede to the service users point that they are attention seeking and others deserve therapeutic intervention more, via signals of agreement (line 21 and 24).

At the end of extract one the service user depicts their emotional distress as non-pathological and transient (line 25), through the utilisation of minimisations "just a bit" and "sometimes" (Freesmith, 2007). The service user also utilises alternative non-pathological terms to depict their distress "sad" (see chapter eight). All of the above creates a negative construction of self and support the argument that they are attention seeking and wasting resources. This is used to downplay distress and simultaneously position the service user as both requiring help and being un-deserving of help as they are not as distressed or depressed as others.

10.3.3. Strategy Two: "I'm just a shadow of what I used to be" - Constructing Identity as Altered by Depression and Depicting a Loss of Self:

In extract one the service user constructs the self negatively to downplay their distress and situate them self as undeserving of therapeutic intervention. In extract two the negative self is positioned as a result of depression and the therapist and service user depict the notion of two selves; an old non-depressed self and a new depressed self. The service user constructs the depressed self negatively and the non-depressed self as strong and independent to manage accountability for depression. The second extract is taken from the last fifteen minutes of the service user and therapist's third therapy session. In the interactional talk prior to this extract the service user was discussing their turbulent relationship with their spouse. The service user also depicted how they keep going over things in their head and that they are not strong enough to change. This section of analysis focuses on how the self is constructed during CBT sessions for depression and how depression is accounted for.

Extract Two – Service User SUG and Therapist T04:

1	**Therapist:**	You say you never used to be like this↑ °n now°
2	**Service User:**	**>**Me<
3	**Therapist:**	>Yeah<
4	**Service User:**	Never::
5	**Therapist:**	Mm
6 7	**Service User:**	I (.hhh) (1.50) >never never never< (2.20) I I looked after forty:: forty odd cells: running: security↑
8	**Therapist:**	Yeah
9	**Service User:**	I could handle myself: n I used to drive my car: everything::
10	**Therapist:**	Mm
11 12 13	**Service User:**	Go to the dentist: by myself (.) have extractions: fillings: (.) root canals anything↑ (1.20) now I'm just a shadow of what I used to be:↓ (5.23) went to court: with me: first divorce↑
14	**Therapist:**	Mm

15 **Service User:** Did <u>all</u> that by myself:↑

In extract two the service user and therapist construct the service user's identity as altered by depression and depict a loss of self. This change in identity is situated as negative and subsequently introduces the notion of an "old" and "new" depressed self. The "old" self is constructed as strong, independent and reliant, whereas the "new"-depressed self is constructed as weak and dependent on others. Constructing the "old" self as strong and independent shifts accountability, because it rejects the premise that depression is caused by a personal flaw or weakness.

The therapist is the first to introduce the notion of identity change (line 1). This is accomplished by composing the dialogue in the past tense "used" (line 1). The therapist constructs the change in the service user's identity as the service user's affirmation through the discursive device indirect discourse; quoting the talk of the service user (line 1) (Finley and Roberts, 1990). The change in identity is situated as potentially negative through the extreme case formulation "never" (line 1) (Edwards, 2000). Constructing identity as changed subsequently introduces the notion of an "old non-depressed self" and a "new depressed self". The service user attends to the therapist's assertion, by explicitly affirming that a change in identity has taken place; "I (hhh) never never never" (line 6). The service user's emphasised exhale, extreme case formulation and repetition, are used to emphasise the service user's argument, evoke emotion and accomplishes hopelessness and discontent with the change in identity (Edwards, 2000). All of the above is used to construct the notion that the service user's identity has changed. Both the service user and therapist situate this change in identity as negative and orient to this being the consequence of depression.

After establishing that a change in identity has taken place the service user goes on to construct their "old non-depressed" self. This is accomplished by drawing on examples of occupational achievements such as: running security (line 7), and previous undertakings such as driving a car (line 9) and going to the dentist alone (line 11). These examples are utilised to construct the service user's "old" self as strong and independent. Running security is often associated with strength therefore the service user draws on this ideology to position them self as strong and authoritarian. The use of numerical values (line 7) quantifies the achievement and adds to the construction of

strength (Van-Dijk, 2000). The service user constructs independence by situating their old self as not needing to rely on others. Going to the dentist is often depicted as a situation that invokes fear and unease. Therefore "attending the dentist alone", is used as evidence to support the notion that the service user's "old self" was independent and strong. To support their argument further the service user lists specific procedures at the dentist. These extra details build specificity and present the service user's account as informed reliable and accurate (Freesmith, 2007). Furthermore extractions, fillings and root canals are all examples of things that are daunting and unpleasant. This constructs the "old" self as strong and resilient. All of the above is used to support the construction of a previously strong character and that a change in self has occurred.

Situating the "old" self as strong and independent subsequently constructs the "new"-depressed self as weak and dependent on others. Composing the dialogue about the "old self" in the past tense insinuates that a change in identity has taken place and that the service user is no longer able to accomplish these things independently. This is emphasised on lines 12-13, where the service user draws on the metaphor "shadow" to depict the new self (line 12-13). The metaphor demonstrates a loss of self and situates this loss as negative (Stoppard, 2000). The change in tense from past to present (line 12) situates the negative construction of self as referring to the current self, rather than the "old" self. Furthermore, the dialogue depicting the "old self" was emphasised through the utilisation of extreme case formulations, whereas the dialogue depicting the "new self" is downplayed through the utilisation of minimisations (line 12) (Potter, 1996). The comparison between the "old" self and "new" self, situates the new self as undesirable and less proficient compared to the old self.

Constructing identity as changed is used in this extract to manage accountability for depression. Depression is often depicted in the media as a personal weakness or a choice (Gattuso, 2005). In this extract the service user attends to this ideological position. The service user rebuts the notion that depression is caused by personal weakness by situating the "old" "non-depressed" self as strong and independent. This shifts accountability away from the service user and onto depression, because it suggests that depression has made the service user weak, not that the service user was weak and therefore got depression. This subsequently constructs depression as something that can affect strong independent individuals.

10.3.4. Strategy Three: "I was just pretending to be happy" - The Notion of a True self and False Self:

During extract two the service user and therapist construct the service user's identity as altered by depression and depict a loss of self. This subsequently introduces the notion of two selves, an "old" non-depressed self and "new" depressed self. In extract three the service user and therapist construct the notion of a true self and false self. The notion of a true self creates dilemmatic talk whereby the service user constructs two competing discourses regarding the true self; the service user either constructs the depressed self or non-depressed self as the true self. The service user and therapist also negotiate the consequences of concealing depression from others and the impact this has on their identity. The third extract is an exchange between a service user and therapist during their third CBT session. The service user has just been discussing problems at work and not wanting to go out because they will be in a "rubbish" mood. Prior to extract three the service user was discussing the negative thoughts that enter their mind before going out.

Extract Three – Service User SUB-R1 and Therapist T02:

1	**Therapist:**	ok n how about when you: got there::↑
2	**Service User:**	I just (.) uh I was just pretending to be happy:: n just↓
3 4	**Therapist:**	Ok (.) so when you got there↑ you (.) just tried to act like your normal:: self so you were: (.) chatty:: n
5	**Service User:**	Yeah::
6 7 8	**Therapist:**	Was there anything different about how (.) you behaved: when you got there: (.) t how you would normally be (.) do you think↑
9 10 11	**Service User:**	(3.40) mm (5.04) I don't think (.) I don't think so: (2.20) but it's just all kind of like just fake: though↓ (.) like (.) in the back of my head: I'm still just like:
12 13	**Therapist:**	Does that go through your mind when your:: (.) in the situation↑
14	**Service User:**	Yeah:
15	**Therapist:**	You're thinking (.) I'm: fake:↓

16	**Service User:**	Mm yeah:
17	**Therapist:**	Yeah:
18 19	**Service User:**	I don't want people to like know that I'm down or put attention to myself so: (5.09)
20	**Therapist:**	Do you worry about people noticing:: (2.32)
21	**Service User:**	No (.) I think I hide it quite well
22 23	**Therapist:**	Ok (9.02) when you think:↑ I'm fake (.) how does that make you feel (7.06)
24	**Service User:**	Just that I'm not being myself↑ n:
25	**Therapist:**	Yeah:: (2.41)
26	**Service User:**	Things: aren't: how they used to be:: (4.07)
27 28 29	**Therapist:**	((*mumbles as if writi*ng)) Things aren't how they used to be (4.09) and if you think (.) so↑ if you are: being fake (.) what does that mean: to you
30	**Service User:**	that's something's wrong: like: if I'm not being myself↑
31 32 33	**Therapist:**	Yeah (.) ((*mumbles as if writing*)) so something's wrong I'm not being myself (2.14) and what: does that say about you (3.08) if that was true::
34	**Service User:**	I don't know (.hhh)
35 36	**Therapist:**	What's the worst thing about that (.) that you're not being yourself↑ (.) what does it mean↑
37 38	**Service User:**	Just the fact that mm I'm being fake towards my friends:: they don't know how I'm really feeling::
39 40	**Therapist:**	Ok so they don't know how you're really feeling:: (.) and what does that mean:: (9.12)
41	**Service User:**	I've got to:: do this constant (.) act in front of them: (3.42)

Here the service user and therapist construct the notion of two selves; i.e. the true self "being myself" and the false self "being fake". Being myself or being true to myself is a well-established repertoire and the service user can be seen to orient to this cultural maxim within the extract.

The service user situates their behaviour as false when interacting with others and depicts them self as unhappy (line 2). The therapist attends to this by reformulating the service users prior dialogue and constructing the notion of a true self (line 3-8) (Perakyla *et al* 2008). This is accomplished by depicting the service user's "normal" self and insinuating a change in behaviour may have occurred; that the service user is concealing from others (line 3-8). The therapist's use of the term "normal" to depict the service user's non-depressed self consequently situates the service user's depressed self and behaviour as abnormal (Bennet *et al* 2003). The service user rejects the therapist's assertion that they behaved differently in front of others (line 9) and constructs them self as fake for concealing their depressed self (line 10). Here the service user is adhering to the cultural maxim of being true to your self. Not adhering to this cultural norm is constructed negatively and referred to as "being fake" (line 10). This positions the service user's true self as their depressed self, which is in contrast to the therapist who constructed the true self as the "normal" or non-depressed self. This creates an ideological dilemma whereby there are two competing discourses regarding the true self (Goodman, 2007). The service user constructs the true self as how they feel whereas the therapist constructs the true self as how you normally behave. This ideological dilemma is positioned around violating the cultural norm that you should be "true to your self".

The service user constructs the notion of the true self to demonstrate their uneasiness around disclosing being depressed to others. The service user depicts concealment of depression as negative and positions them self as fake for concealing how they feel. However, the service user also situates people knowing about their depression as negative (line 18-19). This creates dilemmatic talk whereby the service user is constructed as fake for violating the cultural maxim and concealing their depressed self but depicts unease around disclosing how they feel to others (Goodman, 2007). This situates depression and the depressed self as potentially negative and open to disparagement from others.

Violating the cultural maxim by "not being myself" (line 23 and 29) is constructed here as not expressing how you feel. This positions the depressed self as the true self and suggests that a change in identity has occurred (line 26). Violating the cultural maxim by concealing depression from others is presented as negative and that something is potentially "wrong" if they are concealing their true self (line 30). The therapist attends to the dilemma regarding concealment and "being myself" by asking what implications

this has regarding the service user's identity (line 31-36). The service user attends to this questioning by reiterating that they are fake because others do not know how they feel and that they are putting on an act (line 37- 41).

Both discursive features construct the service user's identity as changed. This is similar to extract two where the service user constructed the notion of two selves. However, in contrast to previous extracts, in extract three the depressed self is presented as the service user's "true" self, rather than constructing depression as masking their identity.

In the previous extract the service user drew on the notion of a "fake" self as they concealed depression from others. However, in extract four this notion is used by another service user as a plea for help and to disclose being depressed to the therapist. Extract four is taken from half way through the service user's and therapist's second session. In the dialogue immediately prior to extract four the service user and therapist were discussing having no confidence and losing their ability to socialise with friends.

Extract Four – Service User SUE-R1 and Therapist T04:

1	**Therapist:**	Ok so we talking about what↑ going out with friends n stuff
2	**Service User:**	**>**Yeah<
3	**Therapist:**	Yeah ok ok (2.04) ok (1.50) so you are good at it↓
4	**Service User:**	I'm good at it on that level↑ on a social level but actually::
5	**Therapist:**	>Yeah<
6 7 8	**Service User:**	I'm not gaining much o<u>u</u>t of it because I'm not connecting (1.52) they think they're having a great time with me n I think I'm having a great time but act<u>ually</u>:
9	**Therapist:**	Mm
10 11	**Service User:**	When I go away from it I'm still (.) down (.) I try n distract myself:
12	**Therapist:**	Yeah so
13	**Service User:**	I'm not gaining I I just don't feel <u>at at</u> peace with anything↓
14	**Therapist:**	>Ok so you're sort of putting on a false self<
15	**Service User:**	Yeah which is great n it's all good fun at the time but (1.54)

16		actually you know↑ it involves alcohol: n going out:
17	**Therapist:**	Mm
18	**Service User:**	**>**N being distracted<
19	**Therapist:**	Mm:
20	**Service User:**	Like
21	**Therapist:**	What would you rather be like↑
22	**Service User:**	Just just peace: n just inner peace
23	**Therapist:**	Mm
24	**Service User:**	I have no inner peace
25	**Therapist:**	Mm (2.40) ok

Here the service user depicts their distress and orients to being depressed. This is accomplished firstly by describing apathy "I'm not gaining much out of it" (line 6). The description of apathy situates the service user as lacking enjoyment for an experience they previously enjoyed. A lack of enjoyment is situated as the result of not connecting with their friends (line 6). This orients to withdrawal and isolation, accomplishes distress and signals that a change has taken place. Secondly the service user depicts deceiving others and themselves (line 7-8), which constructs concealment and the notion of a "false" self. This is followed by a disclosure of depression "I'm still down" (line 10). The disclosure constructs depression as state of being that cannot be altered or ignored. The service user draws on the metaphor not being "at peace with anything" (line 13) to depict apathy, anguish, struggle and depression as disruptive (Khan *et al* 2007). All of the above construct distress, change and the service user as depressed, which are utilised as a plea for help.

The therapist reformulates the service user's depiction of distress and disclosure of depression as putting on a "false" self (line 14) (Perakyla *et al* 2008). This interpretive repertoire positions the service user as concealing their true depressed self from others and themselves. This interpretive repertoire is composed in a hesitant non-committal manner through the false start (Potter, 1996). The service user attends to this with agreement and constructs the "false" self positively, utilising terms such as "great" and "fun" (line 15). However, the service user also suggests that the "false" self is fleeting and

maintained through "distraction" (line 18) "alcohol" (line 16) and "going out" (line 16). In turn this positions the true depressed self as unhappy and a more permanent state. The construction of a "false" self is used here to depict the service user's distress, and demonstrate how others are unaware of their distress. The therapist attends to the service user's depiction of distress and the "false" self as a plea for help and asks; "what would you rather be like" (line 21). This line of questioning is more oriented to the service user's identity and attempts to elicit information regarding what the service user requires help with. The service user attends to this by drawing on the interpretive repertoire inner peace (line 22) and a lack of it is used to infer distress and the presence of depression (line 24) (Seymour-Smith *et al* 2002). The repetition of this repertoire emphasises distress and invokes emotion. The use of the metaphor "inner peace" to depict depression throughout this dialogue constructs depression as internalised and invading the self (Khan *et al* 2007). All of the above is used to depict an internal battle between the self and depression and is composed as a plea for help.

Overall in extract four the service user depicts distress and orients to being depressed by describing apathy, withdrawal and a "false" self. Depression is constructed as invading the self and the service user depicts an internal battle between the self and depression. In both extracts three and four the depressed self is constructed as the true self. However it needs to be emphasised that this construction is temporally situated because it refers to a construction of the self at a particular moment in time and in a specific context, the therapeutic setting. Therefore the construction of the depressed self, being the true self may not be the same in another context.

10.3.5. Strategy Four: "I don't think I have enough will power to change my self" - Constructing the Self as Blameworthy for Depression:

The previous extracts have examined how the self is constructed and used to place responsibility for depression elsewhere. It has also examined the notion of a "false" self and by implication a true self. The following section of analysis will look at how the service user constructs the self, with a particular focus on how the service user blames themselves for their depression and emotional distress. During extract five the service user constructs the self as blameworthy for their depressed state. Constructing the self as accountable for their depression is used to accomplish hopelessness and an inability to recover from depression. Extract five is an exchange between a service user and therapist taken from the first fifteen minutes of their fifth therapy session. In the

dialogue prior to this extract the service user and therapist discussed the service user's negative thoughts regarding missing a session and attending a music concert with their partner.

Extract Five – Service User SUF-R1 and Therapist T04:

1	**Therapist:**	N what was you thinking (.) what was your thoughts↑
2 3 4 5 6 7	**Service User:**	Umm (2.43) that if I (.) couldn't even enjoy one thing that I would normally enjoy↑ (1.40) then↓ (.) it's such: it's such a simple thing (.) that↓ (.) if that even can't be changed: then: >what is the point in even trying you know↑ n I'm pretty sure [*therapist*] doesn't like me as well because he thinks I'm attention seeking< (.) and all of this weird stuff:: (h)
8 9	**Therapist:**	(h) ok:: (.) umm: (2.03) right↓ (8.34) OK: shall we put it on the board↑
10	**Service User:**	Go on then↓
11	**Therapist:**	Yeah↑
12	**Service User:**	Yeah
13 14 15 16 17	**Therapist:**	Umm ok so the situation (5.02) umm ok (2.01) gig: on: night: urr (.) not crying too:: (1.50) question (1.20) right ok:↑ (2.02) so: umm:↑ (.) the: urr: (.) so↑ I suppose the main: thing the main thing is not coming to the session↑< isn't it really>
18	**Service User:**	**>**Yeah<
19 20 21	**Therapist:**	Yeah so ok (.) your thoughts were (2.00) wondering if [*therapist*] doesn't like me: (4.22) I'm attention seeking↑ (.) is that a thought↑ yeah↑ (7.20) <ok what else↑> (.)
22 23	**Service User:**	**<**I (.) don't (.) think> (1.50) I can: (3.00) I don't think I have enough (.) will power: (.) to change↑ (.) my self :
24 25	**Therapist:**	ok (10.40) Ok: umm: haven't got enough will power↑ (2.20) anything else↑ (8.37)
26 27 28 29	**Service User:**	I couldn't enjoy the thing I was meant to enjoy↑ I was looking forward to it and I didn't enjoy it and (.) I thought <I can't enjoy:> (.) it's all simple I just wanted to enjoy: it and I can't
30	**Therapist:**	Ok (1.50) ok (3.00) I can't enjoy this: ok (.) so:: behaviours↑

31 32	**Service User:**	Umm (.) I (.) when I was there well↑ actually I <removed myself from both situations didn't I↑>
33	**Therapist:**	So you::
34 35	**Service User:**	To a degree (.) I didn't really I didn't walk out of the gig↓(.) but
36	**Therapist:**	So what did you do sat down on the floor↑ or::
37	**Service User:**	Yeah

At the start of extract five the service user blames the self for being unable to enjoy things they would normally enjoy and constructs themselves as lacking willpower (line 2-3). This accomplishes apathy, a common symptom of depression and signifies that a change has taken place. The use of the term "simple" constructs the self as inept because they are unable to do "simple" things (line 3). This creates a self-critical account. The service user then goes on to accomplishes hopelessness and despair by constructing the self as unable to be changed (line 4-5). This situates the service user as trying but simultaneously constructs failure and a lack of willpower (line 5). The frequent use of first person pronouns and negative language directs the dialogue towards the service user and attributes the cause of apathy to the service user rather than depression (Freesmith, 2007). All of the above creates sense of hopelessness and perceived inability to change.

The therapist attends to the service user's declaration of apathy, self-loathing, lack of willpower and hopelessness by asking for more information regarding the event, the thoughts that occurred during the event and what the service user's main concerns are (line 13-21). However, the service user continues to construct the self as blameworthy for their depressed state (line 22-23). During this dialogue the service user constructs the self as unable to change due to a lack of willpower (line 22-23). This situates the service user as wanting to change but lacking the personal attributes needed to implement this.

The service user constructs two conflicting versions of the self, what they want and what they're able to do. The conflict between these two constructions of the self presents dismay and frustration (Lafrance and Stoppard, 2006). The repetition of "I can't" and "I couldn't" (line 26-29) emphasises the service user's distress by demonstrating how good the external event (the gig) was (or at least should be) (line 26-29). The absence of an

explanatory phrase situates apathy as the result of the "self" rather than any external cause or attribution to illness. The frequent use of first person pronouns between lines 22-29 adds to this, it directs the discourse towards the service user and accomplishes blame for their lack of enjoyment (Potter, 1996). This section of dialogue infers helplessness and anguish at the self for experiencing apathy.

The therapist does not acknowledge the service user's construction of distress. Instead the therapist asks about "behaviours", a key component of CBT formulation. This dismissal encourages the service user to move topic and focus on behaviours engaged in during the concert (line 31-37).

10.3.6. Strategy Five: "That's my trouble" - Constructing Depression as Invading the Self:

Similar to extract five, in extract six the service user constructs themselves as accountable for their depressed state. At the start of the extract the service user blames them self for their negative thoughts and ruminating. However, at the end of the extract the service user objectifies their thoughts and depicts them as the cause of their depression. This reduces the service user's accountability and in turn constructs depression as taking over the self; rather than part of their identity, as demonstrated in extract five. Extract six is an exchange between a service user and therapist and is taken from the first fifteen minutes of the third therapy session. In the dialogue prior to this extract the service user and therapist discussed how the service user's week, leading up to their session, had been

Extract Six – Service User SUG and Therapist T04:

1	**Service User:**	I mean (.) Wednesday morning: I had I woke up (.) n I:
2		(1.20) I relived: everything: that's that's my trouble↑ I
3		relive↑ things: that are not good for me::
4	**Therapist:**	Mm
5	**Service User:**	You know↑ I just can't switch off or see to them (.) I need to
6		Know:
7	**Therapist:**	Wh what do you get out of reliving (.) >those things<
8	**Service User:**	I don't I: don't if I'm honest: you know:↑

9	**Therapist:**	Mm
10	**Service User:**	It hurts: me: it destroys all my umm (2.20) everything:
11	**Therapist:**	Mm
12	**Service User:**	Especially my mind: (.) my mental health:
13	**Therapist:**	Mm::

At the start of the extract the service user situates them self as accountable for their negative thoughts, ruminating and depressed state (lines 1-6). The repetition of first person pronouns throughout the dialogue situates the talk as referring to the service user and creates ownership (line 1-3). The use of the terms "trouble" (line 2) and "not good" (line 3) depicts the service user's rumination as problematic and having negative consequences for the service user. It also creates a self-critical account whereby the service user attributes their behaviour to their depressed state. However, the service user then goes on to situate their negative behaviour as out of their control and constructs depression as something external that is happening to them (line 5-6). Situating the self as lacking agency of their thoughts reduces the service user's accountability for their depressed state (Lafrance, 2007). In the dialogue prior to this the service user took ownership for their behaviour. However, constructing a lack of control situates the service user's thoughts as a compulsion rather than a choice. The therapist questions the service user's depiction, asking what the service user gets out of ruminating (line 7). The therapist's question is aligned to the service user's initial depiction between lines 1-3, where the service user positioned them self as accountable for their rumination. This question also acts as a signal of agreement, that the service user's rumination is problematic and that they are accountable (line 7).

The service user initially responds to the therapist's question, with the preferred response; that they are not gaining anything from reliving things and ruminating (line 8). However, the service user changes their pronoun choice from "I" (line 1-6) to "it" (line 10) (Potter, 1996). This reduces the service user's agency of their thoughts and presents depression as something external that is happening to them. This in turn situates the thoughts as responsible for their depressed state. This reduces the service user's agency as it shifts accountability onto the negative thoughts. The service user depicts the negative impact the thoughts have upon the self. This is accomplished through the utilisation of negative and illustrative terms; "hurt me" and "destroys me"

(line 10). This conjures an image of torment and destruction caused by the thoughts. This is aided by the use of extreme case formulations (line 10) (Fresmith, 2007). The pronoun choice "me" and "my" situates the self as affected by the thoughts (line 10).

The display of impact upon the self culminates on line 12, where the service user explicitly situates the thoughts as impacting their mental health. This again situates the thoughts as a distinct entity consuming the service user's mind (line 12). What is interesting in extract six is the contrast between line 1-3 and lines 10-12. On lines 1-3 the service user attributes their distress as caused by their ruminating. However, between lines 10-12 the service user attributes their distress to their thoughts, which are situated as ontological and not within their control.

10.4 Discussion:

This analysis identified five key discursive strategies to construct self identities during CBT sessions for depression: depression invades the self, the negative construction of the self, the lost self, the "true" self and the "false" self and the self as blameworthy for depression. These strategies were used to downplay distress, position the service user as undeserving of help, manage accountability for depression, convey distress and hopelessness, ascertain help, and position the self as unable to recover from depression.

10.4.1. Implications for the Literature:

To date no discursive research has looked at how service users and therapists construct identity during CBT sessions for depression. Therefore, this analysis provides a unique perspective regarding the construction of the self and identities. Previous literature has either analysed identity in systemic or psychoanalytic therapy, or retrospectively via interviews with individuals who previously had an episode of depression. This is the first analysis to look at how identity is constructed in CBT sessions for depression. In addition to this the current analysis has identified five novel findings that contrast or expand previous literature, regarding the construction of identity by individuals deemed to have depression.

Firstly, it is well established that individuals with a diagnosis of depression have negative outlooks and a tendency to engage in negative verbal behaviour (Beck, 1967;

Rude *et al* 2004; Hinchliffe, *et al* 1971). Therefore, an anticipated finding from this analysis was that service users construct themselves negatively. However, a novel finding from this analysis was that the negative self-construction was accomplished in three ways; constructing the self as unlikable, constructing the self as attention seeking and constructing the self as wasting time and resources. The negative constructions of self were used by the service user to downplay distress, situate others as worse off and position them self as undeserving of therapeutic intervention. The negative construction of self was attended to by the therapist as evidence of depression or *negative thoughts generated by dysfunctional beliefs.* This led to attempts to challenge the service user's negative constructions, in line with CBT practice.

Consistent with previous findings in recovery discourse, the notion of two identities (the depressed and non-depressed self) were used by the service user to manage accountability for depression. However, the current analysis builds on previous literature regarding the notion of two selves in four ways. Firstly, in the current analysis the notion of the depressed and non-depressed self was utilised to construct the service user's identity as altered by depression and to depict a loss of self. Secondly, in this analysis accountability was not managed by constructing normality but by emphasising that depression is not due to personal weakness and is something that can affect strong independent individuals. Thirdly previous literature does not provide much detail regarding how the depressed and non-depressed selves are constructed. The current analysis demonstrates how the old non-depressed self was situated as strong, independent and reliant by drawing on previous personal and occupational accomplishments. This in turn situated the "new" depressed-self as weak and dependent on others. Lastly, this analysis provides an insight into how the two selves are used to manage accountability for depression during therapeutic interactions with service users deemed by the PHQ-9 to have depression.

The third novel finding from this analysis was the use of the notions of the true and false self. Previous discursive literature suggested that in recovery discourse, individuals who previously had an episode of depression construct their non-depressed self as the "authentic self". However, the current analysis found that during therapeutic interactions the service user constructed the depressed self as the "true" or "authentic self". Here, authenticity was constructed as how one "really feels". However, the therapists constructed the true self as the non-depressed self, in line with previous literature. The construction of the depressed self as the "true" self, created an ideological

dilemma whereby concealment was situated as necessary to avoid disparagement but also constructed as negative because it violated the cultural maxim of being true to yourself. Violating this norm positioned the service user as "fake" or putting on a false self. It could therefore be concluded that the "true self" is always constructed as the current self. This would explain the contrasting findings regarding the true self in individuals currently seeking help for depression and individuals who previously had an episode of depression. When the therapist constructed the true or false self this tended to be via reformulation, a device that CA researches identified (Perakyla *et al* 2008). Reformulation is where the therapist attributed meaning to the service user's dialogue (Perakyla *et al* 2008). The use of this device is convergent with the wealth of CA literature on psychotherapy. It is also worth noting that the construction of the true self as the depressed self is temporally situated because it refers to a construction of the self at a particular moment in time and in a specific context, the therapeutic setting. Therefore the construction of the depressed self as the true self may not be the same in another context. This is consistent with literature regarding configurations of the self during therapy, which postulates the concept of a plural self rather than unified self. Whereby the service user draws on different constructions of the self to accomplish different discursive actions during therapy (Cooper and Rowan, 1999). Furthermore literature focusing on person centred therapy and the self found that service users often talk about different parts or configurations of the self and the therapist often invites talk around these different configurations (Mearns and Thorne, 2000). However the findings in this chapter are novel because previous literature has focused on psychotherapy or person centred therapy and this is the first examination of the construction of the self during CBT.

Another novel finding from the current analysis was that service users constructed an internal battle and constructed depression as invading the self. This conveyed distress, torment and unrest. It also constructed depression as an internal trait with permanency. Depression was also constructed as taking over the self. This enabled individuals to attribute their behaviour to depression and construct a lack of control. This lack of control was used to manage accountability and construct depression as impacting the self. This finding builds on non-discursive research regarding the construction of depression which found that when individuals described overcoming depression, they constructed depression as a threat and an enemy (Glasman *et al* 2004).

Lastly, a key finding from previous discursive examinations of identity found that individuals construct identity to manage accountability for depression and resist claims of being inherently flawed (Wilson and McLuckie, 2002; Pitcher, 2013). However, a unique finding from the current analysis was that service users construct the self as blameworthy for depression. When positioning the self as blame worthy, the service user constructed them self as inept and utilised self-critical dialogue. Constructing the self as accountable for depression was used to convey hopelessness and an inability to recover from depression.

10.4.2. Implications for Clinical Practice and Summary:

An understanding of how identity is constructed in therapy could aid clinical practice because it would provide the clinician with a better understanding of the service users' self-constructions and how depression impacts the construction of self. An understanding of what the constructions of self accomplish in CBT is important for clinical practice because it provides knowledge regarding service users' objectives.

The current analysis found that the way the self was constructed created resistance and misalignment between the therapist and service user. In addition to this because of the central role of the self in the CBT paradigm, therapists often focused on challenging negative self-constructions or attended to them as evidence of negative thoughts. This often led to a dismissal of the service users' constructions of distress. Chapter seven developed these findings, by focusing on the implementation of CBT strategies and examining troubled responses. Both chapters seven and ten provide an understanding of therapeutic processes and highlight effective ways of communicating in therapeutic interaction to enable cohesion and therapeutic alliance.

10.4.3. Conclusion:

Identity and the self are central features of the cognitive model of depression. However, relatively little research has investigated how individuals with depression negotiate and construct identity. The current analysis provides a unique perspective regarding the construction of identity. The current analysis identified five novel findings that contrast or expand previous literature, regarding the construction of identity in individuals currently seeking help for depression. A key finding was that the authentic self was

constructed as the depressed self, which contradicts previous literature. This has implications regarding concealment and caused misalignment between the therapist and service user. Although this is a novel finding it has limitations regarding generalizability because the dialogue is taken from a specific context (CBT sessions) and from a specific sample (trainee therapists). Therefore future research should endeavour to determine if this is consistent across therapeutic disciplines and across therapist experience levels. Doing this could also aid clinical practice because in order to accomplish rapport and therapeutic alliance, clinicians need to be aware of how identity is constructed during therapy and what these constructions accomplish.

Chapter Eleven - Discussion:

11.1 Overview:

The overall aim of this thesis was to discursively examine therapeutic interactions between therapists and service users during Cognitive Behavioural Therapy (CBT) sessions for depression. The discussion chapter covers seven issues. It will first highlight what the discursive evaluation of therapeutic interactions demonstrates, by highlighting how the aims of the thesis have been accomplished and demonstrating what we know now that we did not know before. Secondly, general analytical findings that cut across all analysis chapters will be discussed. Thirdly, this chapter will demonstrate the thesis' wider implications for literature and highlight new issues that have arisen as a result. Fourthly methodological contributions will be discussed. Fifthly, implications and recommendations for clinical practice based on the findings from the thesis are highlighted. Sixthly, the chapter will then go on to discuss future research directions and limitations. Lastly, the chapter will close with concluding remarks. Overall this chapter will aim to bring together the thesis and highlight what the thesis has contributed to literature and clinical practice.

11.2 Contributions:

11.2.1. What the Discursive Evaluation of Therapeutic Interactions Demonstrates:

Following discursive psychology, this thesis aimed to examine the ways that service users' and therapists' talk was used to perform actions during therapeutic interactions. The actions found to be performed during therapeutic interactions included, but are not limited to, managing ideological dilemmas regarding being "true to yourself" and the concealment of depression; managing accountability for depression; positioning the service user as a victim of biology or social circumstance; situating recovery as out of the service user's control; legitimising time off work and atypical behaviour; incurring empathy; resisting the label of depression; eliciting depictions of problems; and resistance to CBT formulation. The analysis also brought to light what happens and what is talked about during therapeutic interactions. This provides knowledge regarding how service users and therapists construct distress, depression, identities and factors contributing to why they are attending therapy. It also highlighted how therapists discursively accomplish, or not, the therapeutic aim and how service users attended to

therapeutic questioning. Therefore, this thesis highlights what happens during CBT sessions and provides an in-depth knowledge of the discursive actions accomplished. This is a novel contribution because to date no discursive research has focused on how service users and therapists jointly construct depression during therapeutic interactions, how identity is constructed during CBT sessions or how CBT principles are constructed in interaction and how cognitive behavioural strategies are implemented and attended to during therapeutic interactions. This enhances knowledge within several areas of literature and has implications for clinical practice.

The overall aim of discursively examining therapeutic interactions was accomplished in four analytic chapters that evaluated the implementation of cognitive behavioural strategies and how they are attended to, addressed how depression was constructed in CBT sessions, without utilising the terms "depressed" or "depression", conducted a deviant case analysis of how the terms "depressed" and "depression" were utilised during therapeutic interactions and examined how the self and identities are constructed during CBT sessions. The research questions engaged with the issues highlighted in previous literature regarding depression construction, CBT and therapeutic interactions. The following section demonstrates how the thesis' research questions were answered.

11.2.1.1. Analysis One - A Discursive Examination and Evaluation of The Implementation of Cognitive Behavioural Strategies and How They Are Attended to:

The thesis builds on, and contributes to, discursive work in the field of therapeutic interactions (Edwards, 1995; O'Reilly, 2014). Although a number of studies have discursively examined therapeutic interactions, limited research has focused on CBT. This research differs from previous studies because previous discursive literature regarding therapeutic interactions has largely focused on systemic and psychodynamic therapy (Stratton, 2003; Nye, 1994). Only two studies have discursively examined therapeutic interactions during CBT (Beattie *et al* 2009; Messari and Hallam, 2003). Furthermore, to date no discursive research has examined how cognitive behavioural strategies are implemented and attended to within CBT sessions. The effectiveness of CBT strategies is currently assessed via the CTS-r. However, this reduces therapeutic dialogue to a numerical value. Therefore, this thesis provides additional insights regarding therapeutic interactions during CBT sessions. This is because the thesis is the

first to discursively evaluate therapeutic interactions during CBT, the first to provide an understanding of how cognitive behavioural strategies are implemented and attended to, and examine their discursive effectiveness. Chapter seven aimed to answer the following research questions:

- How are CBT strategies implemented during CBT sessions?
- How are CBT strategies attended to?
- How are items, assessed via the CTS-r, constructed in talk?
- Are the CBT strategies effective in terms of: inducing the preferred response, encouraging dialogue and alignment?

11.2.1.1.1. What Do We Know Now That We Did Not Know Before?

In answering these questions, an assessment of how CBT strategies work in interaction and an identification of the extent to which they 'work', by identifying the discursive features of effective and ineffective implementation of CBT strategies has been accomplished. Congruent with previous literature, the thesis demonstrated that therapists utilise various discursive devices during therapeutic interactions, such as: quasi-direct discourse; joint productions; and creating a multi-authored narrative (Ferrara, 1992; Finlay and Robertson, 1990; Lewis, 1995; Couture, 2007; Kogan and Gale, 1997). However, the current analysis found that these discursive devices were more prominent in the extracts that effectively accomplished the therapeutic aim. A novel finding from the thesis was that in addition to the already established discursive devices, the extracts that effectively accomplished the therapeutic aim had other defining features: attending to the elicitation of emotion and notions highlighted as important; encouragement and positive reinforcement; and therapists' questions were gradually composed as open questions. All of these features were used to encourage dialogue, demonstrate understanding and create empathetic responses.

The thesis also builds on previous literature regarding resistance and weak therapeutic alliances (Roy-Chowdhury, 2006; Grabborn *et al* 2005). It demonstrated that the therapeutic aim was not accomplished when the CBT strategy did not elicit the preferred response, did not promote dialogue and there was evidence of therapeutic misalignment. A novel finding highlighted in the thesis was that when the therapeutic aim was not accomplished, the therapists' questions were closed. These questions were

attended to with troubled responses, i.e. resisting the therapist or responding with short answers that attempted to stop questioning. Another novel finding was that troubled responses tended to occur when accounting for depression or the terms "depressed" and "depression" were utilised.

A novel finding highlighted in the thesis was that the therapist could accomplish the therapeutic aim but neglect other mediating factors such as depictions of hopelessness and distress. Here the therapist did not attend to emotion or issues highlighted as important by the service user. This created a lack of understanding and demonstrated un-empathetic responses, which is incongruent with Item Five on the CTS-r. Here the therapists' questions were shorter, more direct and often required a yes or no response. This prohibited the service user from providing the dispreferred response but also prohibited the service user from answering openly and freely.

11.2.1.2. Analysis Two - Utilising Alternative Terminology to Discursively Construct Depression in CBT Sessions:

The thesis builds on, and contributes to, work in the field of therapeutic interactions and the construction of depression (Lafrance, 2007; Teghtsoonian, 2009). Although a number of studies examined how depression is constructed by clinicians (e.g. Johnstone and Frith, 2005) and individuals with a diagnosis of depression (e.g. Pitcher, 2013), no research has focused on how service users and therapists jointly construct depression in UK therapeutic settings. As such, chapter eight provided additional insights regarding how depression is jointly constructed during therapeutic interactions. This is because the research focus differs from previous studies regarding the construction of depression by utilising naturalistic data, rather than interview data, in which depression is explicitly discussed (Bennett *et al,* 2003). In doing this, the thesis demonstrated that within CBT sessions depression is oriented to but the terms "depressed" and "depression" are often absent from the service users' and therapists' dialogue. Chapter eight addressed the following research questions.

- How is depression constructed in CBT sessions?
- What do the different constructions of depression accomplish and how are they attended to within therapeutic interactions?

11.2.1.2.1. What Do We Know Now That We Did Not Know Before?

In answering these questions, we now know that during therapeutic interactions depression is oriented to and talked about but that the terms, "depressed" and "depression" are often absent from the service users' and therapists' dialogue. This is divergent from previous literature which utilised interview data and suggested that depression is explicitly constructed and talked about, possibly because individuals are explicitly asked to discuss it within research interviews about depression. (Bennett *et al* 2003). Instead of utilising the terms "depressed" and "depression" service users and therapists utilised alternative terms such as "down" "low" and "ill" to construct depression. This is a novel and unexpected finding as the service user is in therapy and depression was the predominate factor according to the GAD-7 and PHQ-9. Even more striking was the absence of the terms "depressed" and "depression" when constructing a biological definition of depression. This highlights that during therapeutic interaction depression is talked about and constructed but the terms "depressed" and "depression" are absent. It was suggested that the absence could be because service users and therapists are rehearsing culturally familiar discourses of depression which construct it as dangerous and negative, and individuals with a diagnosis of depression are constructed as blameworthy (Arboleda-Flórez and Stuart, 2012). Therefore, the service users and therapists might be managing this culturally familiar discourse by avoiding the term depression.

Congruent with previous discursive literature, it was demonstrated that depression was constructed as an illness or a consequence of biology or fraught life events (Calderón *et al* 2012; De Shazer, 1997; Harvey, 2012). Furthermore, previous research focused on justifying treatment choices and explanatory frameworks (Thomas-Maclean and Stoppard, 2004; Young, 2009). Here it was used to manage accountability for depression by situating emotional distress as externally attributed. Although constructing depression as biological in origin was a prominent finding in previous literature (e.g. Lafrance, 2007), it was unexpected in this data because the therapist was from a cognitive behavioural paradigm which is not premised upon the biological basis of depression. Previous discursive literature found this strategy was employed by mental health professionals to justify pharmaceutical treatment or argue that medication is routine (Oliphant, 2009). However, biological terminology was used by the therapist in this analysis to manage accountability by positioning the service user as a passive victim who cannot be held accountable for their "faulty biology". A consequence of this is that it

situates recovery as being out of the service user's control, which is contrary to CBT's theoretical underpinning (Hawton *et al* 1989). This discursive action could be used to create an empathetic response to demonstrate understanding and accomplish rapport, important notions according to the CTS-r. However, this suggests that aspects of CBT are in conflict with each other (this will be discussed in more detail later in the chapter). Unlike constructing depression as a consequence of external factors or faulty biology, "being ill" was constructed as the causal factor because it lacked a set of triggers. This is in opposition to previous literature which found individuals compared depression to physical illness, to incur empathy and tolerance (Issakainen, 2014; Schreiber and Hartrick, 2002). In the data depression was constructed explicitly as the illness, in an attempt to incur these typical responses and present others as intolerant of their depression.

11.2.1.3. Analysis Three - Utilising the Terms "Depressed" and "Depression" How Service Users and IAPT Therapists Discursively Construct Depression in IAPT Therapy Sessions:

Previous research assumes depression is explicitly constructed and talked about. Therefore, no analyses have looked at how the terms are utilised and what utilising the terms accomplishes within therapeutic interaction despite this analysis demonstrating that explicitly naming depression is rare. As such, this thesis provided additional insights about the utilisation of the terms "depressed" and "depression" because this is the first discursive analysis to focus on the utilisation of the terms. In doing this it draws strongly on the work from non-discursive literature that found depression is constructed as either an experience of "having" or "being" (Harvey, 2012; Fromm, 1979). However, this research differs from previous studies because it utilised a discursive methodology and examined what these different constructions are accomplishing in therapeutic interactions because to date no discursive research has done this. Chapter nine aimed to answer the following questions:

- How are the terms "depressed" and "depression" utilised during therapeutic interactions?
- What does the utilisation of the terms "depressed" and "depression" accomplish?
- How is depression constructed and attended to within therapeutic interactions?

11.2.1.3.1. What Do We Know Now That We Did Not Know Before?

While it has been shown in chapter eight that the use of the terms "depressed" and "depression" are generally absent, in the unusual cases where the terms are used it is done to emphasise distress, construct distress, demonstrate a lack of control and manage accountability for distress and recovery. This is a novel finding. Congruent with non-discursive literature, service users constructed their accounts around two reoccurring constructs: "I am depressed" and "I have depression" (Harvey, 2012; Fromm, 1979). However, what is now known is that the terms "depressed" and "depression" have different uses. The lexicogrammatical differences between the terms were found in this thesis to have different implications regarding aetiology, prognosis, trajectory and identity. An unexpected finding highlighted in the thesis was that when service users and therapists utilised the terms "depressed" and "depression", they oriented to a need for delicacy. They also oriented to being labelled as depressed as negative. This finding is divergent from previous discursive literature that found that labelling is situated as a positive because it brought relief, validation and legitimisation (Lafrance 2007; Wisdom and Green, 2004; Issakainen, 2014). Taken together with chapter eight these findings demonstrate that the terms "depressed" and "depression" are potentially problematic and that depression does not have a fixed meaning, but it is used flexibly by speakers to accomplish a range of actions within CBT.

11.2.1.4. Analysis Four - Identity Construction in Accounts for Depression During Cognitive Behavioural Therapy (CBT) Sessions:

The thesis builds on and contributes to discursive work regarding how individuals with depression (according to the PHQ-9) construct identity (Boardman *et al* 2011; Cruwys and Gunaseelan, 2016). Although a number of studies have examined identity construction in individuals who have had a depressive episode (Stoppard, 2006), to date no discursive research has examined how individuals currently seeking help for depression construct identity during CBT sessions. Therefore, this thesis provides additional insights into identity construction in accounts for depression during CBT sessions. This research also differs from previous studies because it examines identity construction during therapeutic interactions whereas previous studies were conducted retrospectively via interview (Bennet *et al* 2003). Chapter ten aimed to answer the

following research questions:

- How do service users with depression construct the self during CBT sessions?
- What do the different constructions of self accomplish?

11.2.1.4.1. What Do We Know Now That We Did Not Know Before?

In answering these questions, we now know that five key discursive strategies are utilised to construct the self and identities in CBT sessions for depression. The five discursive strategies were: (1) the negative construction of the self, (2) the construction of a lost self, (3) the distinguishing of a "true" self and a "false" self, (4) constructing the self as blameworthy for depression and (5) the use of an invasion metaphor to describe depression. The self was constructed in various ways: to ascertain help, to convey distress and to manage accountability for depression and recovery.

Although the negative construction of self is not surprising given that individuals with a diagnosis of depression often engage in negative verbal behaviour (Beck, 1968) and the service users in this research are shown to have symptoms of depression according to the PHQ-9 (Beck, 1967), to date no discursive analyses have examined how the self was constructed negatively. Here the service users depicted an internal battle and constructed depression as invading the self. Congruent with previous discursive literature, the notion of a depressed and non-depressed self was utilised by service users (Bennet *et al* 2003). However, this strategy was not utilised to convey normality but to manage accountability, construct identity as altered by depression and to depict a loss of self. An unexpected finding from the thesis was that service users constructed the self as blameworthy for depression. This is divergent from previous discursive examinations of identity, which found that individuals construct identity to manage accountability for depression and resist claims of being inherently flawed (Wilson and McLuckie, 2002; Pitcher, 2013). Another unexpected finding from this thesis was that during therapeutic interactions the service user constructed the depressed self as the "true" or "authentic self". This is divergent from previous discursive literature which suggested that individuals who had an episode of depression in the past construct their non-depressed self as the "authentic self" (Bennet *et al* 2003). The notion of the "true self" created an ideological dilemma regarding concealment of depression from others; whereby concealment was situated as necessary to avoid disparagement but also as

negative because it violated the cultural maxim of being true to yourself. Furthermore the construction of the true self as the depressed self is temporally situated because it refers to a construction of the self at a particular moment in time and in a specific context, the therapeutic setting. This is consistent with literature regarding configurations of the self during therapy, which postulates the concept of a plural self rather than unified self (Cooper and Rowan, 1999). Furthermore literature focusing on person centred therapy and the self found that service users often talk about different parts or configurations of the self and the therapist often invites talk around these different configurations (Mearns and Thorne, 2000). However the finding of the depressed self as the authentic self is novel because previous literature has focused on person centred therapy and this is the first examination to find the construction of plural selves in CBT.

11.2.2. General Analytic Findings:

Section 11.2.1. demonstrated what each analysis has contributed to literature and explicated what we know now, that we did not know before. The next section looks at the findings from across all analytical chapters and how these findings have contributed to literature and knowledge, regarding therapeutic interactions.

11.2.2.1. Accountability:

A consistent finding from across the analysis was the management of accountability. From a DP perspective, it is expected that speakers manage accountability in talk (Potter, 1997). This analysis has demonstrated the specific ways that the speakers are doing this during therapeutic interactions. Therapists managed accountability and blame for depression and recovery on behalf of the service user. In addition to this, service users sometimes positioned them self as blameworthy for depression to infer hopelessness and an inability to recover from depression. How accountability is managed in CBT is discussed below.

Service users managed their accountability for having depression. In doing so they also constructed what depression is, i.e. a consequence of biology or fraught life events. This was used to shift the focus away from the service user and reduce accountability by implying that the cause of depression does not lie solely with the individual. The service

user is therefore managing their accountability for depression by constructing their emotional distress as externally attributed. The therapists used biological terminology to manage accountability by positioning the service user as a passive victim who cannot be held accountable for their "faulty biology". However, a consequence of this is that it situated recovery as out of the service users' control which is contrary to CBT's theoretical underpinning. This discursive action could be used to create an empathetic response to demonstrate understanding and accomplish rapport which is an important discursive action according to Item-Five on the CTS-r. However, this again suggests that aspects of CBT are in conflict with each other (this will be discussed in more detail later in the chapter). Furthermore, service users often constructed depression as an "illness" and themselves within the subject position of an "ill" individual. This marginalised the role of the service user in their experience of depression which subsequently reduced accountability for depression, atypical behaviour and time off work.

Another way service users managed accountability for depression was via the construction of two identities, the depressed and non-depressed self. However, unlike previous literature which has shown how these two identities are managed (Bennet *et al* 2003; Lafrance and Stoppard, 2006), here accountability was not managed by constructing normality but by emphasising that depression is not due to personal weakness and is something that can affect strong independent individuals. This emphasised the notion that depression has made the service user weak, rather than that they were weak and therefore got depression. In addition to constructing two selves to manage accountability for depression, service users also constructed depression as taking over the self. This enabled individuals to attribute their behaviour to depression and situate themselves as lacking control. This lack of control was used to manage accountability for behaviour and construct depression as impacting the self. This finding builds on non-discursive research regarding the construction of depression which found that when individuals described overcoming depression, they constructed depression as a threat and an enemy (Glasman *et al* 2004). Although the different discursive strategies identified above construct depression in different ways, they also share similarities. They all construct depression as an abnormality that needs to be accounted for. Thus, the therapists and service users are trying to construct depression as within the range of "normal" human experience. Managing accountability for depression and potentially atypical behaviour has its limitations because it consequently situates depression and the service users' behaviour as something that needs to be accounted for.

Reducing accountability for depression subsequently reduces accountability for recovery, a key aim of therapy. An interesting finding from this thesis was how the therapist carefully manages accountability and blame when attending to the service users' constructions of depression. The therapist attended to the construction of depression as a consequence of negative life events by blurring the conception of internal and external attributions. This created dilemmatic talk whereby the therapist carefully manages blame. The therapists subtly shifted accountability back to the service users by making external attributions internal by rejecting the premise that the service user is to blame for external events, but is responsible for how they react to the external events. This increased the service users' personal accountability for depression and their recovery which is in line with the CBT ethos. The construction of depression as both internally and externally attributed is a novel finding because previously were drawn on separately (Schneider, 2010; Crowe, 2005). However, in this thesis they are used simultaneously to manage blame and accountability. Furthermore, a novel finding in this thesis is that when attending to the service users' construction of depression, the therapist manages accountability on behalf of the service user. This could be to display empathy and increase rapport or because the service user is positioned as vulnerable and unable to manage accountability themselves.

Lastly, a key finding from previous discursive examinations of identity found that individuals construct identity to manage accountability for depression and resist claims of being inherently flawed (Wilson and McLuckie, 2002; Pitcher, 2013). However, a unique finding from the thesis was that service users sometimes construct the self as blameworthy for depression. When positioning the self as blame worthy, the service user constructed them self as inept and utilised self-critical dialogue. Constructing the self as accountable for depression was used to convey hopelessness and an inability to recover from depression. Although this does not fit with the findings above, it does highlight how wider discourses of depression are contributing to how service users construct depression and manage blame, during therapeutic interactions (Arboleda-Flórez and Stuart, 2012).

11.2.2.2. Identity Work in Therapy:

Another consistent finding across all analytical chapters was identity work. During therapeutic interactions service users positioned themselves as passive victims of social

circumstance or biology to manage accountability; constructed depression as separate from identity and a state that impacts perception of the self; distanced the self from depression; constructed the self negatively and as blameworthy for their emotional distress; and constructed the notion of two selves. Each of these is briefly discussed in turn below.

When constructing depression, service users positioned themselves as passive victims of biology or social circumstance to manage accountability. They also constructed depression as separate from identity and a state that impacts their perception of self. This was used to distance the role of the service user in their illness experience. In addition to this they resisted accusations from therapists that being depressed impacts identity, rather than being a trait (or a part of their identity).

Consistent with previous findings in recovery discourse (Bennet *et al* 2003) the service user utilised the notion of two identities, the depressed and non-depressed self. However, here the notion of the depressed and non-depressed self functioned to construct the service users' identity as altered by depression and to depict a loss of self. The thesis demonstrated how the old non-depressed self was constructed as strong, independent and reliant by drawing on previous personal and occupational accomplishments. The notion of two selves was also drawn on to construct a "true and false self". Previous discursive literature suggested that in recovery discourse, individuals who have previously had depression construct their non-depressed self as the "authentic self" (Bennet *et al* 2003). However, the thesis demonstrated that during therapeutic interactions the service user constructed the depressed self as the "true self". The reason for the disparagement between this thesis and previous literature could be that the "true self" is always constructed as the current self. This would explain the contrasting findings regarding the "true self" in individuals currently seeking help for depression and individuals who previously had an episode of depression.

11.2.3. Wider Implications for The Literature:

In addition to the novel findings explicated above the thesis also contributes to wider discussions and highlights new issues regarding depression, therapeutic interactions and discursive psychology. These wider issues and discussions are explicated in turn

below.

11.2.3.1. Service Users and Therapists are Rarely Naming Depression in Therapy for Depression:

A new issue highlighted in this thesis is around the use or non-use of the terms "depressed" and "depression". One of the most notable findings from this thesis was that depression is oriented to and talked about but the terms, "depressed" and "depression", were absent from the service users' and therapists' dialogue. One reason for this could be that because the data is naturalistic, service users and therapists are not required to offer abstract conceptual rumination on depression as they would during an interview. Instead, the service user attends to their day-to-day concerns and the therapist attends to reforming those concerns within the service users' control. This was accomplished by situating matters as addressable by modifying their behaviour in line with CBT principles. This goes some way to explain why in general the terms were largely absent throughout the therapy sessions but prominent in previous literature that largely utilised interview data (Pitcher, 2013). However, it does not explain why, when clearly orientating to depression, the terms are absent. The absence of the terms indicates uncertainty around the concept of depression and that the terms are potentially negative or stigmatising. The absence could therefore be because service users and therapists are adhering to broader cultural conceptualisations of depression; in which depression is constructed as dangerous and negative, and individuals with a diagnosis of depression are constructed as blameworthy (Arboleda-Florez and Stuart, 2012). Therefore, service users and therapists could be managing these negative depictions of depression by avoiding the terms.

The notion that there might be uncertainty around the concept of depression and that the terms "depressed" and "depression" are potentially negative or stigmatising was further supported in chapter nine, where a deviant case analysis was conducted on the use of the terms "depressed" and "depression". It was demonstrated that on the rare occasions the terms are utilised they are constructed hesitantly orienting to a need for delicacy. This finding is divergent from previous discursive literature that found that labelling is constructed as a positive because it brought relief, validation and legitimisation (Lafrance, 2007; Wisdom and Green, 2004; Issakainen, 2014). Whereas here a label of depression is constructed as negative, deterministic and permanent.

Furthermore, troubled responses to CBT strategy implementation tended to occur when the terms "depressed" and "depression" were utilised. This suggests that the utilisation of the terms can also be problematic for therapeutic alliance.

Overall the terms "depressed" and "depression" were utilised in CBT sessions to emphasise distress, construct distress as serious, demonstrate a lack of control over behaviour and resist accusations that the service user is accountable for their distress and recovery. Furthermore, the terms were often utilised after probing from the therapist or when resisting the therapists' formulations. Therefore, the terms "depressed" and "depression" were often utilised as a preferred response, to end a confrontation or to emphasise the speaker's argument.

This is a novel contribution to knowledge around depression because previous literature suggested the use of the terms "depressed" and "depression" is explicit and neglected to examine why the terms are utilised and what utilising these terms accomplishes (Lafrance, 2007). This thesis highlighted that the utilisation of the terms "depressed" and "depression" is potentially problematic and that service users and therapists are rarely naming depression in therapy for depression. This highlights a new conceptual issue for depression and therapy. Therefore, more research needs to be conducted around why the terms are absent, why is the term depression problematic in therapy and why is no one naming depression in therapy for depression.

11.2.3.2. *Defining Depression:*

In addition to contributing knowledge regarding how the terms "depressed" and "depression" are utilised or not during CBT sessions, the thesis also offers a contribution to what is meant by depression. One of the key conceptual issues identified in previous literature was that the way depression is understood and conceptualised varies throughout history, and within formal classification systems (Ban, 2014; First, 2007). Moreover, a widely accepted definition of depression is absent because the DSM and ICD are divergent. This thesis demonstrated how therapists and service users discursively construct depression during CBT sessions, in order to gain a better understanding of what is meant by depression.

A key finding from linguistic examination found that individuals frequently situated

their accounts of depression around two reoccurring constructs: "I am depressed" and "I have depression" (Harvey, 2012; Fromm, 1979). However, non-discursive examinations could not offer suggestions about what these constructions accomplished. The thesis demonstrated that being "depressed" was constructed as: controlling, a transient state separate from identity, an illness, a state that impacted the perception of the self, caused low mood and was the result of social circumstance. Conversely the term "depression" was constructed as controlling, serious, permanent, biological in origin, an objective entity and a known concept or noun. Both constructions were used to manage accountability and minimise the role of the service user in their illness experience. This finding implies that the terms "depressed" and "depression" have very different meanings and the lexicogrammatical differences between the terms have different implications regarding: aetiology, prognosis, trajectory and identity. This finding emphasises the notion that there is no one universal definition of depression and the way depression is conceptualised varies between service users and therapists in CBT sessions.

In addition to demonstrating that "depressed" and "depression" have different uses and different implications, the thesis highlighted that congruent with previous literature depression was constructed as an illness or a consequence of biology or fraught life events (Calderón *et al* 2012; De Shazer, 1997; Harvey, 2012). Furthermore, previous literature suggested that these constructions were utilised to explain depression or justify treatment choices (Johnstone and Frith, 2005). In the thesis, these strategies were used to shift the focus away from the service user and reduce accountability by implying that the cause of depression does not lie solely with the individual.

These findings add to the conceptual issues identified in previous literature that a widely accepted definition of depression is absent (Ban, 2014; First, 2007). This thesis demonstrated that the way depression is understood varies in clinical practice and shows how the terms "depressed" and "depression" are used flexibly to accomplish specific and separate actions. Although the thesis cannot provide a universal definition of depression, it can be shown that what is meant by depression varies and depression is often constructed as the result of biological or social circumstance; an illness; and something that invades and changes the self. A fuller understanding of what is meant by depression could aid the issues highlighted above regarding why service users and therapists are rarely utilising the terms "depressed" and "depression" in therapy for depression.

11.2.4. Implications and Recommendations for Clinical Practice and Training:

Discursively evaluating therapeutic interactions during CBT sessions has highlighted techniques that could be used to improve clinical practice because it provides an insight into how therapeutic dialogue is constructed and what it accomplishes. It also provides an insight into what is talked about during CBT sessions and how service users construct depression, identity, manage accountability for depression and why they are in therapy. Understanding these issues allows therapists to negotiate and combat issues that could arise in therapy and subsequently cause misalignment or generate troubled responses. This thesis could therefore be used as a teaching resource or an in-depth guide to therapeutic interactions. Overall, the findings from this thesis could contribute to clinical practice. In light of this, subsequent recommendations for training and practice have been generated. The implications and recommendations are demonstrated below.

11.2.4.1. One - Rapport and Therapeutic Alignment:

Overall the absence of the terms "depressed" and "depression", the varied constructions of depression and the hesitant utilisation of the terms were demonstrated to have implications for clinical practice. Firstly, it demonstrated delicacy and hesitation around these terms. Secondly, it demonstrated that the label of depression is potentially negative or stigmatising, and the terms are taboo. Thirdly, it suggested that there is uncertainty around the concept of depression and that the terms "depressed" and "depression" have different uses that had implications regarding aetiology, prognosis, trajectory and identity. In addition to this, the use of the terms "depressed" and "depression" created unease, resistance and misalignment between the therapist and service user which was demonstrated to have an impact on rapport and accomplishing the therapeutic aim. This finding has implications for clinical practice because not understanding what the term "depression" means to an individual, could result in damaged rapport or accidently condemning an individuals' identity rather than validating distress.

11.2.4.1.1. Recommendations:

- CBT training should highlight that the terms "depressed" and "depression" have different uses and highlight this as a potential issue for therapeutic alignment.

- Clinicians need to be aware that the terms "depressed" and "depression" have different implications regarding aetiology, prognosis, trajectory and identity.

- When utilising the terms, clinicians need to understand what these terms mean to service users. A lack of awareness could impact the service users' understanding of treatment, prognosis, aetiology and reduce rapport. To increase awareness of this issue, the training handbooks and guides given to trainee CBT therapists should highlight what each of the terms could mean to service users and how they were used in therapeutic interactions. This would provide clinicians with a better understanding of the service users' objectives and aid clinical practice.

    - For example, when the service user utilises the terms "depressed" and "depression" they are usually trying to demonstrate distress, seriousness and a lack of control over behaviour, and resist accusations that the service user is accountable for their distress and recovery. Displaying empathy and understanding after a disclosure of depression could aid rapport and ensure the service user feels understood (this was done well in chapter nine extract two).

    - For example, when the service user utilised the term "depressed" but the therapist utilised the term "depression", it caused an impasse in dialogue and misalignment between service user and therapist. This made the therapeutic aim hard to achieve and caused a troubled response. To overcome this issue therapists should ensure they understand what the service user means by the terms "depressed" and "depression", and should utilise the same terminology as the service user.

- One way to increase therapeutic alignment and accomplish rapport would be to have an initial discussion with service users at the start of therapeutic interactions. This discussion should focus on the service users' understanding of

the "terms "depressed" and "depression" to identify the implications the use of these terms would have on aetiology, recovery and prognosis.

11.2.4.2. Two - Managing Accountability for Recovery:

During therapeutic interactions service users managed accountability for depression. However, reducing accountability for depression subsequently reduces accountability for recovery, a key aim of therapy. The therapist therefore attempted to combat this issue by subtly shifting accountability back to the service user by recasting external attributions as internal factors within the service users' control. This increased the service users' personal accountability for depression and their recovery. This has implications for clinical practice because shifting accountability onto the service user enables the service user to take ownership of recovery and situates change as possible.

11.2.4.2.1. Recommendations:

- CBT is about taking responsibility for ones' thoughts and the impact thoughts have on behaviour, emotion and physical symptoms. However, this creates a dilemma because to encourage agency is to implicitly blame the service user. This is a source of tension because service users frequently resist accountability for depression and position themselves as passive victims of illness, biology and social circumstance. Therefore, the CBT agenda to internalise attributions (and accountability) can often become problematic. To combat this issue and remain in line with the therapeutic aim, therapists need to both acknowledge and validate that many things that can impact the service users' mental health are beyond the service users' personal control (e.g. social inequality), while at the same time encouraging agency. For example, by challenging the idea that discourses of victimhood and discourses of agency are mutually exclusive by blurring internal and external attributions. Blurring the conception of internal and external attributions for depression to subtly shift accountability back to the service user, should therefore be highlighted to trainee CBT therapists. This would provide them with strategies to combat issues of accountability in therapy whilst enabling the service user to take responsibility for their recovery. However, situating notions as beyond the service users control is potentially challenging an underpinning principle of CBT and will be discussed in more detail in section 11.2.5.1.2.

11.2.4.3. Three – Developing Techniques for Accomplishing the Therapeutic aim and Avoiding Troubled Responses:

The increased understanding of therapeutic interactions and the discursive features of effective and ineffective CBT strategy implementation can aid clinical practice and training. This is because the analysis provides an understanding of how the therapist accomplishes the therapeutic aim. The thesis also examined troubled responses to CBT strategy implementation. For example, troubled responses occurred when therapists' questions were composed as closed questions requiring a certain response. When the desired response was not given it created misalignment between the therapist and service user. The thesis also demonstrated that the way the self and depression were constructed, created resistance and misalignment between the therapist and service user. Therapists often focused on challenging negative self-constructions or constructions of depression and attended to them as evidence of negative thoughts. This often led to a dismissal of the service users' depiction of distress. This aids clinical practice because it provides knowledge regarding how to respond to troubled responses and how to avoid troubled responses in CBT.

11.2.4.3.1. Recommendations:

- Therapists should avoid the use of closed questions and should instead gradually composed open-ended questions to encourage dialogue, demonstrate understanding and create empathetic responses.

- Therapists should mirror the service user's terminology because utilising the term "depression" when the service user utilised the term "depressed" caused misalignment and a breakdown of dialogue.

- Therapists should attend to what the service user highlights as important and the service users' emotional distress, in order to demonstrate understanding, create empathetic responses and avoid troubled responses.

- The therapist should offer encouragement and positive reinforcement to increase dialogue around an issue.

11.2.4.4. Four - Assessment and The CTS-r:

The thesis has implications for the CTS-r and the assessment of the therapist's skill. It was the first to provide a detailed evaluation of how items assessed via the CTS-r are constructed in talk. Specifically, Item Five – Interpersonal Effectiveness, which suggests the service user should feel that warmth, genuineness, empathy and understanding are present. Item Five is the only item on the CTS-r that attempts to assess the therapeutic relationship, the other items are focused on effective CBT strategy implementation. However, the CTS-r does not state how this is discursively accomplished. In addition, one of the most novel findings demonstrated in the thesis was that the therapist could accomplish the therapeutic aim but neglect other mediating factors such as depictions of hopelessness and distress. The therapist did not attend to the elicitation of emotion or what the service user was highlighting as important. This created a lack of understanding and demonstrated un-empathetic responses. Furthermore, the therapists' questions were shorter, direct and required a yes or no response. This prohibited the service user from providing a dispreferred or troubled response but also prohibited the service user from answering openly and freely.

These findings demonstrate that empathy could be in conflict with implementing CBT strategies. Empathy is about demonstrating understanding which is often accomplished by agreeing/aligning ourselves with another person's version of events. However, CBT strategies appear to be about challenging the service users' version of events. This creates a dilemma within CBT whereby the therapist is attempting to demonstrate empathy whilst challenging the service user. Therefore, the CTS-r could be attempting to assess therapists on how well they do contradictory things. This might explain why in some extracts the therapist appeared un-empathetic when accomplishing the therapeutic aim (Chapter seven: extracts Six and Seven); whilst, in other extracts they appeared to be saying things contrary to CBT (e.g. positioning the service user as a passive victim; Chapter Nine: extract Two) but did demonstrate empathy. These findings can be used as a tool for assessment because it provides a more detailed depiction of how Item Five is accomplished in CBT. However, more research needs to be conducted around the dilemma created between CBT and the CTS-r.

11.2.4.4.1. Recommendations:

- Attending to mediating factors and allowing the service user to answer questions freely are important factors for discursively accomplishing empathy and understanding.

- Composing questions gradually, utilising indirect and quasi-direct discourse to create jointly constructed narrative and encourage dialogue, are important factors for creating understanding and empathy whilst accomplishing the therapeutic aim.

- The CTS-r could be updated to reflect the dilemma created between CBT and the CTS-r. For example, CBT requires the therapist to challenge the service user's version of events. However, the CTS-r requires the therapist to demonstrate empathy which is often accomplished by agreeing/aligning ourselves with another speaker's version of events.

11.2.5. Methodological Contributions:

11.2.5.1. Cognitive Behavioural Therapy (CBT) and Discursive Psychology (DP):

11.2.5.1.1. Why Use an Anti-Cognitive Approach to Assess a Cognitive Therapy?

DP and its associated method DA have been effectively applied to the study of therapeutic interactions. However, previous literature has focused on the analysis of systemic or psychoanalytic therapy transcripts (Avdi and Georgaca, 2007). This could be because systemic and psychoanalytic therapy are influenced by constructionism, and therefore fit with the epistemological view of DP. Although CBT and constructionism have philosophic similarities, such as CBT's emphasis on the role of the service users' conceptualisation of events, to date a limited amount of research has utilised DA to examine therapeutic interactions during CBT sessions (Beckworth and Crichton, 2014; Mathieson *et al* 2016). This could be because CBT is a cognitive approach interested in internal thoughts and feelings, whereas DP takes an anti-cognitive approach (Beck, 1964; Potter, 1997). Although this could be why it has been avoided, CBT and DP also share similarities. For example, CBT is a talking therapy and uses talk to accomplish

therapeutic actions such as change (Hawton *et al* 1999). Therefore, CBT is constructed and accomplished through talk. Similarly, DP is interested in how talk and text are used to perform actions (Potter, 2004). It should also be noted that DP does not take CBT at face value. DP is not trying to assess cognitive principles such as thoughts, but instead examine how talk is constructed in therapeutic interactions and what the talk is used to accomplish. Therefore, although CBT and DP may differ in their interpretation of why the discursive action is occurring, what that discursive action means or what the talk represents, they both view talk as important and central. Thus, the theoretical argument regarding why this thesis has used an anti-cognitive approach to assess a cognitive therapy, is quite simply both DP and CBT view talk as important and central.

This thesis has demonstrated that DP, and its associated method DA, can be applied to examine therapeutic interactions during CBT sessions. CBT practitioners should listen to what an anti-cognitive approach finds because this thesis has identified two key benefits of utilising a discursive methodology to examine CBT sessions. Firstly, DA provides an in-depth service evaluation of CBT. It provides an insight and knowledge into what happens during CBT and what is talked about in CBT. This is beneficial for therapists, service providers and service users. Secondly, CBT textbooks and theory provide examples of what should happen in a CBT session (Hawton, 1989) but a DA provides an insight into what actually happens. It provides knowledge around troubled responses and how they can be avoided, how to enhance therapeutic alignment and an insight into what the action orientation is within the talk so that therapists can gain an understanding of what the service user is trying to accomplish with their talk.

11.2.5.1.2. What Does This Thesis Say About CBT?

Two key inconsistencies/dilemmas in CBT have been identified in this thesis. The first is regarding accountability. CBT is about taking responsibility for ones' thoughts and the impact thoughts have on behaviour, emotion and physical symptoms. However, the thesis demonstrated that this creates a dilemma because to encourage agency is to implicitly blame the service user. This is a source of tension because a general finding that cut across all analytic chapters was that service users frequently resist accountability for depression and position themselves as passive victims of illness, biology and social circumstance. Therefore, the CBT objective to internalise attributions (and accountability) can often become problematic. Chapter Seven extract three, demonstrated an example of where encouraging agency resulted in troubled talk and a

resistance to CBT. Additionally it was found that therapists often managed accountability for depression on behalf of the service user, frequently positioning them as passive victims. Doing this was highlighted as a way of increasing rapport and understanding, however this moves away from placing the service user as responsible. Therefore, there could be an inconsistency within CBT whereby the therapist is attempting to convey rapport and understanding, whilst increasing agency and implicitly blaming the service user. The therapist is attempting to do contradictory things which could explain why in some extracts the therapist is attempting to encourage agency, and in others reduce agency. In section 11.2.4.2.1 a recommendation to combat this issue and remain in line with the therapeutic aim was highlighted (i.e. blurring the conception of internal and external attributions for depression to subtly shift accountability back to the service user). This recommendation was highlighted as a way to both acknowledge and validate that many things can impact the service user's mental health are beyond the service user's personal control (e.g. social inequality), while at the same time encouraging agency. However, situating notions as beyond the service user's control is still potentially challenging an underpinning principle of CBT. Therefore encouraging agency is either compromised or a source of tension in therapeutic interactions.

Secondly, the thesis demonstrated that empathy could be in conflict with implementing CBT strategies. Conveying empathy is noted as an important aspect in CBT and is assessed via item five on the CTS-r. Empathy is about demonstrating understanding which is often constructed in talk by agreeing/aligning with another person's version of events. However, CBT mechanisms such as Core Belief (CB) strategies are used to identify, challenge and modify dysfunctional beliefs about the self, world and future. These strategies aim to undermine and challenge the fundamental assumptions on which depressive thinking is based (Padesky, 1994). This creates a dilemma within CBT whereby the therapist is attempting to demonstrate empathy whilst appearing to challenge the service user. Therefore, the CTS-r could be attempting to assess therapists on how well they do contradictory things. This might explain why in some extracts the therapist appeared un-empathetic when accomplishing the therapeutic aim (Chapter Seven: extracts Six and Seven); whilst, in other extracts they appeared to be saying things contrary to CBT (e.g. positioning the service user as a passive victim; Chapter Nine: extract Two) but did demonstrate empathy. This could also explain why encouraging agency is a point of tension in therapeutic interactions.

Although the thesis has highlighted these inconsistencies in CBT, it is not the aim to comment on whether these inconsistencies impact the outcome of therapy because no outcome measures were assessed. What this thesis can say is that agency is often a source of tension in therapy, and empathy (an important aspect highlighted across therapeutic disciplines) is often in conflict with the theoretical underpinnings of CBT. Therefore more research should be conducted on the promotion of agency and the construction of empathy in CBT. Future research should also investigate whether the inconsistencies in CBT highlighted in this thesis have implications for treatment outcome. In addition to this the CTS-r needs to accommodate the issues surrounding empathy when assessing the therapist's skill.

11.2.5.2. Benefits of Naturalistic Data:

The majority of discursive CBT literature focuses on service users' experiences of CBT and examines this retrospectively via a discourse analysis of interview transcripts (Beattie *et al* 2009; Messari and Hallam, 2003). Similarly, the majority of discursive research focusing on depression has examined this retrospectively via interview (Lafrance, 2007). A very limited amount of discursive literature focuses on therapeutic interactions during CBT. This thesis utilised CBT sessions as a data source because it provided a wealth of naturalistic data (Potter, 2004). Therefore, the interactions between service users and therapists are not influenced by the researcher's agenda (Potter, 2004). The data in this thesis is as naturally occurring as possible because the sessions would have happened and been recorded regardless of the research (Potter, 2004). The research in this thesis therefore meets Potter's conceptual 'dead social scientist test': "would the data be the same, or be there at all, if the researcher got run over on the way to work? An interview would not take place without the researcher there to ask the questions; a counselling session would take place whether the researcher turns up to collect the recording or not" (Potter, 2002: 541).

One of the key benefits of utilising naturalistic data in this thesis was the identification of new conceptual issues. For example, that depression is oriented to and talked about but the terms, "depressed" and "depression" were absent from the service users' and therapists' dialogue. Because previous literature utilised interview data the participants in that research were required to offer abstract conceptual rumination on depression (Pitcher, 2013). Furthermore, depression was made an issue for investigation by the researchers. Here because the data is naturalistic, service users and therapists are not

required to offer abstract conceptual rumination on depression. Instead, the service user attends to their day-to-day concerns and the therapist attends to reformulating those concerns as being within the service users' control. This enables the generation of novel questions and issues that are driven by the data not the researchers' agenda (Potter, 2004).

However, to ensure the data remained naturalistic, no research intervention occurred between the service user and researcher, except via the participant information sheet. This means that a limited amount of demographic information was collected because all demographic information was acquired via the recordings. Therefore, only the demographic information the service user made salient was included in the research. This was not deemed to be a limitation because this information was not salient to the analysis of therapeutic interactions. Jowett (2016: 4) suggested that demographic information about the speaker is arguably of less interest to discursive researchers than the way in which the speaker constructs an identity within the interaction itself. This is because for discourse analytic approaches, it is the interaction or textual representation of the research topic that is of interest, rather than the 'real' identities of the people assumed to lie behind the text (Jowett, 2016: 4). The importance of this is demonstrated in chapter ten where the analysis focuses on how identity is constructed in talk. Here the relevance of the 'real' identities (demographic information) of the people assumed to lie behind the text was not of interest, but rather how the speaker constructed their identity. However, in alignment with Schegloff's (1997; 1999) argument around participant orientations, the thesis considered identity categories (e.g. gender, age, ethnicity) relevant to the analysis when these categories were made relevant, within the interaction by speakers themselves (Kitzinger, 2000). This is why only demographic information that the service user made salient was included in the research. Furthermore, although the research employed a diverse sample, some of this diversity was screened out because recordings from individuals whose first language was not English were excluded from the data set. This exclusion criteria was imposed because the transcription of these sessions, where the first language was not English, was too complex and the essence of what was being said was lost through hesitation and misuse of grammar and specific words.

11.2.5.3. Participant Orientations:

The argument surrounding participants' orientations is longstanding and complex (see section 6.9) (Schegloff, 1997; 1999; Wetherell, 1998). The debate regarding participants' orientations has occurred to ensure discursive research is 'bound to the data', and does not risk becoming merely ideological. Moreover, analysis must capture at least in part, the demonstrable original significance of the dialogue. The position taken in this thesis challenges Schegloff's claim that depression would need to be directly oriented to by participants, and aligns with Wetherell's (1998) position. This is because it has been demonstrated that depression is already relevant given the specific conversational setting and that the interaction would not have occurred had depression not been an issue which the service user was seeking help for through CBT. This means that the automatic relevance of depression cannot be ignored, due to the interactional setting and purpose of the interactional dialogue.

Although this thesis argues that depression was salient because of the context/nature of the CBT setting, it can also build on and expand Schegloff's (1997: 183) argument. The current thesis took Schegloff's (1997: 183) notion that depression can only be made relevant when the speaker can be seen to orient to its relevance further (Schegloff, 1997: 183). It was suggested that service users and therapists *can* orient to depression (making it relevant) *without explicitly naming depression* in their dialogue (see chapter eight). This thesis therefore builds on this long-standing argument and suggests that individuals can orient to relevance, but do not need to name it, for it to become relevant.

11.2.5.4. Treatment Outcome:

Due to data sharing concerns regarding access to the service users' PHQ-9 and GAD-7 scores, the Course Director of the CBT PGDip/MSc programme at Coventry University was the only person to have access to the service users' pre and post therapy GAD-7 and PHQ-9 scores, to ensure the scores were kept confidential. This means that no inferences can be made regarding how the service users' and therapists' talk impacts upon treatment outcome. Nor can any inferences be made about the effectiveness of the therapists' implementation of CBT strategies with regards to treatment outcome or depression symptomology reduction. Within this analysis, effectiveness of strategies is referring to the apparent discursive effectiveness. Future research could explore this in

more detail, looking at how the service users' pre and post therapy GAD-7 and PHQ-9 scores relate to the discursive strategies identified within this thesis.

11.3 Future Directions:

11.3.1. Areas for Future Analysis:

The restraints of the thesis in terms of word limits and scope meant that some interesting facets that were highlighted in the transcripts could not be included in the thesis. Therefore, future research can address these findings. The interesting facets identified in the transcripts that will be written up as future research include:

Doing Emotion: This feature appeared in the majority of transcripts. It included the use of laughter, explicit language, raised voices and crying. Emotion was used by both the service user and therapist and was often used to elicit sympathy, emphasise distress, attribute blame and trivialise what was said or to change topic. Although the thesis touches on this aspect, a future paper would focus on how service user and therapists do emotion in therapy.

Managing Attributions for Depression: This facet of talk appeared in many of the transcripts. The service user and therapist drew on many reasons to account for depression, such as: life events, work, friends, family, childhood, watching soaps, the service user, money, bereavement, failings, genes, chemical makeup, making mistakes, thinking too much, the brain, drink and drugs, fear and the unknown. This was a broad theme and elements of this can be seen in how service users and therapists construct depression (chapters eight and nine) and construct the self (chapter ten). However, future research could focus on this discursive strategy more exclusively to provide an in-depth discursive evaluation of managing attributions for depression.

Physical Symptoms: This feature of talk was prominent in discussions regarding the effects of depression. Service users often used this notion to: argue for the detrimental effects depression has on their quality of life, objectify depression and establish victim status. Physical symptoms included: colitis, headaches, body aching, muscles being tense, not sleeping and feeling tired or drained. Future research could focus on how the discursive repertoire *physical sensations*, is utilised by service users and attended to by therapists during CBT sessions.

Being mad and Insane: This identity work was seen in two ways. Firstly, the self was occasionally constructed as mad or insane to position the self as inherently flawed and beyond help. Secondly, service users often described others as mad or insane for misunderstanding them and treating them unfairly because of depression. Elements of this theme can be seen in chapter eight where the service user positions them self as misunderstood and unduly stigmatised by others. Future research could focus more exclusively on the repertoire *being mad*, to explore how this cultural maxim is utilised to position the self or others as flawed, and how therapists attend to this.

Progress and Recovery: This feature of talk noted positive remarks to change and progress. The service user and therapist often highlighted areas of improvement and change and referred to a 'switch in mind set'. This feature often occurred in the latter stages on therapy and was used to demonstrate improvement and construct happiness. Future research could focus on how progress and recovery are oriented to and constructed in CBT. This provides clinical practice with an insight into how CBT works and how shifts in dialogue indicate change.

11.3.2. Areas for Future Research:

The research findings within this thesis have expanded and added to existing literature and highlighted new issues within the field of depression and therapeutic interactions. In doing this, areas of future research have been identified. These areas of future research will enable the development of the field and allow others, including myself to expand and develop this area of research.

11.3.2.1. Why is Naming Depression in Therapy for Depression Problematic?

The thesis highlighted a new conceptual issue for depression and therapeutic interactions. It demonstrated that in therapy for depression service users and therapists are rarely naming depression, that the terms are utilised hesitantly and often caused misalignment. This all oriented to depression being problematic and potential uncertainty around the meaning of depression. Therefore, because this is a new and novel finding, future research needs to be conducted around why the terms "depressed" and "depression" are absent in therapeutic interactions, why these terms are problematic in therapy and why there is unease around these terms. This could be

accomplished by discursively examining dialogue during CBT training and to ask therapists to conduct a lay-persons discourse analysis on their own transcripts submitted for assessment. This would provide another level of understanding to the issue regarding depression conceptualisation and why the terms are absent. This would build on the findings presented in this thesis and increase knowledge around depression and the use or non-use of the terms. This could be accomplished by examining how depression is conceptualised by individuals with and without a diagnosis of depression, and if this changes over the course of therapy. Future research could also examine whether the way depression is conceptualised, or the use or non-use of the terms, has implications for treatment outcome. This could be accomplished by examining the utilisation of the terms during CBT and then comparing this to the pre and post GAD-7 and PHQ-9 scores. This would provide an insight into what the implications of not utilising the terms in therapy have on treatment outcome. It would also enable the development of comprehensive training and guidelines regarding the use of terms.

11.3.2.2. Understanding of What is Meant by Depression:

The thesis built on the conceptual issue identified in previous literature that a widely accepted definition of depression is absent. The thesis demonstrated that the way depression is understood varies in clinical practice and that the terms "depressed" and "depression" have different meanings which had implications for trajectory, aetiology and treatment outcome. The thesis could not provide a universal definition of depression but could show how constructions of depression are varied and that the terms "depressed" and "depression" are used flexibly to accomplish specific and separate actions. Because this finding is novel, more research like the thesis could be conducted around what is meant by depression. This is because it would aid the issues highlighted above regarding why service users and therapists are rarely utilising the terms "depressed" and "depression" in therapy for depression. The research could be accomplished by: exploring what the term "depression" means to lay individuals and mental health professionals; examining CBT training to gain a clearer understanding of how depression is constructed during teaching; explore when it is appropriate to utilise the terms in therapy; and explore why there is a difference between the terms "depressed" and "depression".

11.3.2.3. The CTS-r Assessment Process:

The thesis discursively examined the implementation of CBT strategies and their discursive effectiveness. This is currently assessed via the CTS-r which reduces therapeutic dialogue to a numerical value. The thesis is the first analysis to provide a detailed evaluation of how items assessed via the CTS-r are constructed in talk. These findings can be used as a tool for assessment because it provides a more detailed depiction of how items are accomplished in CBT. However, this thesis largely focused on Item Five – Interpersonal Effectiveness. Future research will aim to provide a detailed evaluation of how all items assessed via the CTS-r are constructed in talk. This will provide clinical practice with a comprehensive assessment tool and increase the depth of assessment.

11.3.2.4. Developing CBT Training:

Overall the thesis could be considered an in-depth service evaluation of CBT practice. Therefore, one of the aims of future research is to utilise the findings to improve the CBT PGDip/MSc programme at Coventry University. It can be used to develop comprehensive teaching resources and combat issues such as troubled responses and accomplishing the therapeutic aim whilst demonstrating empathy and understanding. It can also be used to teach trainees about the conceptual issues regarding depression meaning and the lack of utilisation of terms. It can also be used to demonstrate where misalignment between service users and therapists occurs. This will provide trainees with a comprehensive insight into CBT, how to construct therapeutic dialogue and how to attend the service user's constructions of depression and management of accountability. These aims will be accomplished by working with teaching staff and the director of the CBT PGDip/MSc programme at Coventry University.

11.3.2.5. How Do Therapeutic Interactions During CBT Sessions Compare to Therapeutic Interactions During Other Therapeutic Paradigms Such as Mindfulness, Person Centred Therapy and Psychodynamic Therapy?

A broader area of further research would be to analyse therapeutic interactions from other paradigms to identify if the issues around depression construction are apparent in these interactions or if depression is constructed differently. This would enable a more

in-depth understanding of the issues highlighted in this thesis and further develop the overall aim of the thesis to discursively examine therapeutic interactions.

11.4 Concluding Remarks:

Overall the thesis provides a unique perspective regarding the construction of depression, because to date no discursive research has looked at how service users and therapists jointly construct depression during therapeutic interactions. This is also the first analysis to look at how depression is constructed in a UK therapeutic setting, and the first discursive analysis to look at how identities are constructed during CBT sessions for depression. The thesis also provides a unique perspective regarding therapeutic interactions during CBT, because it is the first discursive research to look at how cognitive behavioural strategies are implemented and attended to. Furthermore, this thesis is the first to discursively analyse how items assessed via the CTS-r are constructed in talk.

In addition to adding to the current literature regarding depression and therapeutic interactions, the thesis identified two new conceptual issues and contributes to wider discussions. Such as why are the terms “depressed” and “depression” problematic in therapy; why is no one using these terms in therapy for depression; and what is meant by depression. Finally, discursively evaluating therapeutic interactions during CBT sessions has aided clinical practice because it provides an insight into how therapeutic dialogue is constructed and what it accomplishes. It also provides an insight into what is talked about during CBT sessions and how service users construct depression, identity and manage accountability. Understanding these issues allows therapists to negotiate and combat issues that could arise in therapy and subsequently cause misalignment or generate troubled responses.

This thesis has added to and developed previous literature, expanded knowledge regarding depression and therapeutic interactions, contributed to clinical practice and made recommendations for future research and CBT training. Therefore, the thesis has made a novel contribution to knowledge and could be utilised as a teaching resource for the CBT training programmes.

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Appendix

Appendix 1: DSM-III diagnostic criteria for Major Depressive Episode

Some materials have been removed due to 3rd party copyright. The unabridged version can be viewed in Lancester Library - Coventry University.

Figure 1: DSM-III diagnostic criteria for Major Depressive Episode (American Psychiatric Society, 1980)

Appendix 2: Participant Information Sheet Service user Copy

Participant Information Sheet

Study Title: A Discursive Evaluation of Mental Health Service Interactions

What is the purpose of the research?
The purpose of the research is to conduct a service evaluation of the IAPT service. The service evaluation will provide a fuller understanding of the way in which individuals aiming to gain support for their mental health problems, interact with service providers.

Why have I been chosen to participate?
For the purposes of the research, a large group of IAPT service users have been chosen. You have not been chosen for any other reason.

Do I have to participate?
No. Participation is entirely voluntary. If you change your mind about participation you can withdraw at any point during your therapy session. This decision will not impact upon your therapy session or your IAPT service use. Furthermore, you can also withdraw at any time in the week following your IAPT session. This can be achieved by contacting the lead researcher (Lottie Rowe), on the email address below and providing your participant information number or during your next IAPT session by notifying your therapist. If you decide to withdraw, all your data will be destroyed and will not be used in the research. There are no consequences to deciding that you no longer wish to participate in the research.

What will happen in the Research?
If you consent to your IAPT session being recorded, then the recording will be used as part of a service evaluation. You are not being asked to do anything you are not already doing, as sessions are often recorded for training purposes. The location of the IAPT therapy session, the date of the session, the session number and your GAD-7 and PHQ-9 scores in your first IAPT therapy session will be documented, as part of the service evaluation. The service evaluation will allow professionals and academics to gain a fuller understanding of the way in which individuals aiming to gain support for their mental health problems negotiate with service providers.

What are the potential disadvantages of participation?
Although I do not anticipate any problems, I appreciate that participation will involve you being recorded.

What are the possible benefits of taking part?
As a service user of IAPT, you would be contributing to a service evaluation of the IAPT service. You would also be aiding professional and academic understanding. Although, you are unlikely to personally benefit from this research, the research is hoping to identify ways to help people get what they want from IAPT.

What if something goes wrong?
If you change your mind about taking part in the study you can withdraw at any point during the initial IAPT assessment. You can also withdraw at any time in the week following that session by contacting the lead researcher (Lottie Rowe) via the email address stated below or during your next IAPT session by notifying your therapist. If you decide to withdraw, all your data will be destroyed and will not be used in the research.

Will my participation be confidential?
Participation will be kept anonymous, as you will only be identified via an arbitrarily assigned participant number. Anonymised quotes from what you say may be used as part of the research, but I will ensure that you will not be identifiable in these quotes. Consent forms will be stored separately from the recordings. Recordings and transcripts will be kept in a locked metal cabinet. Once the recording has been analysed it will be destroyed in accordance with Coventry University's policy regarding data storage and deletion.

What will happen to the results of the service evaluation?
It is intended that the results will help evaluate and improve the IAPT service.
It is also intended that the results will be written up as part of a PhD thesis, for publication in a peer-reviewed journal and/or presented at an academic conference.

Who is organising and funding the research?
The research is organised by Lottie Rowe and is supervised by Simon Goodman (s.goodman@coventry.ac.uk) and Katherine Simons (k.simons@coventry.ac.uk). This project is not externally funded.

Who has reviewed the study?
This study has been through the University Peer Review process and been approved by the Chair of UARC/RDS-C.

Contact for Further Information

Lottie Rowe
Email: ab4886@Coventry.ac.uk

Simon Goodman
Email: s.goodman@coventry.ac.uk

Katherine Simons
Email: k.simons@coventry.ac.uk

If you wish to make a complaint with respect to any component of the research that you were dissatisfied with, you may contact Prof. Ian Marshall (Chair of Coventry University Ethics Committee) – email: Ian.Marshall@Coventry.ac.uk

Appendix 3: Participant Information Sheet Therapist Copy

Participant Information Sheet

Study Title: A Discursive Evaluation of Mental Health Service Interactions

What is the purpose of the research?
The purpose of the research is to conduct a service evaluation of the IAPT service. The service evaluation will provide a fuller understanding of the way in which individuals aiming to gain support for their mental health problems, interact with service providers.

Why have I been chosen to participate?
For the purposes of the research, a large group of IAPT service users and trainee IAPT therapists have been chosen. You have not been chosen for any other reason.

Do I have to participate?
No. Participation is entirely voluntary. If you change your mind about participation you can withdraw at any point. This decision will not impact upon your IAPT training. Withdrawing from the research can be achieved by contacting the lead researcher (Lottie Rowe), on the email address below. You will need to provide your personal research identifier to withdraw from the research. If you decide to withdraw, all your data will be destroyed and will not be used in the research. There are no consequences to deciding that you no longer wish to participate in the research.

What will happen in the Research?
If you consent to your IAPT session being recorded, then the recording will be used as part of a service evaluation. You are not being asked to do anything you are not already doing, as sessions are often recorded for training purposes. Some demographic information will also be collected. The service evaluation will allow professionals and academics to gain a fuller understanding of the way in which individuals aiming to gain support for their mental health problems negotiate with service providers.

What are the potential disadvantages of participation?
Although I do not anticipate any problems, I appreciate that participation will involve you being recorded.

What are the possible benefits of taking part?
As a service user of IAPT, you would be contributing to a service evaluation of the IAPT service and IAPT training. Although, you are unlikely to personally benefit from this research, the research is hoping to identify ways to help people get what they want from IAPT and aid professional and academic understanding.

What if something goes wrong?
If you change your mind about taking part in the study you can withdraw at any time, by contacting the lead researcher (Lottie Rowe) via the email address stated below. If you decide to withdraw, all your data will be destroyed and will not be used in the

research.

Will my participation be confidential?
Participation will be kept anonymous, as you will only be identified via an arbitrarily assigned participant number. Anonymised quotes from what you say may be used as part of the research, but I will ensure that you will not be identifiable in these quotes. Consent forms will be stored separately from the recordings. Recordings and transcripts will be kept in a locked metal cabinet. Once the recording has been analysed it will be destroyed in accordance with Coventry University's policy regarding data storage and deletion.

What will happen to the results of the service evaluation?
It is intended that the results will help evaluate and improve the IAPT service.
It is also intended that the results will be written up as part of a PhD thesis, for publication in a peer-reviewed journal and/or presented at an academic conference.

Will this Impact my IAPT training?
No, this research will not impact your IAPT training. The recordings will be analysed by the lead researcher (Lottie Rowe), who is not involved in your supervision or assessment. All extracts used in the research will be anonymised and will not be used as part of your supervision or assessment.

Who is organising and funding the research?
The research is organised by Lottie Rowe and is supervised by Simon Goodman (s.goodman@coventry.ac.uk) and Katherine Simons (k.simons@coventry.ac.uk). This project is not externally funded.

Who has reviewed the study?
This study has been through the University Peer Review process and been approved by the Chair of UARC/RDS-C.

Contact for Further Information
Lottie Rowe
Email: ab4886@Coventry.ac.uk

Simon Goodman
Email: s.goodman@coventry.ac.uk

Katherine Simons
Email: k.simons@coventry.ac.uk

If you wish to make a complaint with respect to any component of the research that you were dissatisfied with, you may contact Prof. Ian Marshall (Chair of Coventry University Ethics Committee) – email: Ian.Marshall@Coventry.ac.uk

Appendix 4: Evidence of Ethical Approval

REGISTRY RESEARCH UNIT

ETHICS REVIEW FEEDBACK FORM

(Review feedback should be completed within 10 working days)

Name of applicant: Lottie Rowe.....

Faculty/School/Department: [Faculty of Health and Life Sciences] Psychology

Research project title: A Discursive Evaluation of Mental Health Service Interactions

Comments by the reviewer

1. Evaluation of the ethics of the proposal:

The ethics proposal is sound.

2. Evaluation of the participant information sheet and consent form:

Doesnt seem to be applicable at this stage.

3. Recommendation:

(Please indicate as appropriate and advise on any conditions. If there any conditions, the applicant will be required to resubmit his/her application and this will be sent to the same reviewer).

X	Approved - no conditions attached
	Approved with minor conditions (no need to re-submit)
	Conditional upon the following – please use additional sheets if necessary (please re-submit application)
	Rejected for the following reason(s) – please use other side if necessary
	Not required

Name of reviewer: Anonymous .....

Date: 11/11/2013 .....

REGISTRY RESEARCH UNIT

ETHICS REVIEW FEEDBACK FORM

(Review feedback should be completed within 10 working days)

Name of applicant: Lottie Rowe.....

Faculty/School/Department: [Faculty of Health and Life Sciences] Psychology

Research project title: A Discursive Evaluation of Mental Health Service Interactions

Comments by the reviewer

1. Evaluation of the ethics of the proposal:

The project has already been approved. This application requests use of data for analysis for a PhD study. No new information is requested from participants so no new risks.

2. Evaluation of the participant information sheet and consent form:

Clear and relevant and previously approved.

3. Recommendation:

(Please indicate as appropriate and advise on any conditions. If there any conditions, the applicant will be required to resubmit his/her application and this will be sent to the same reviewer).

X	Approved - no conditions attached
	Approved with minor conditions (no need to re-submit)
	Conditional upon the following – please use additional sheets if necessary (please re-submit application)
	Rejected for the following reason(s) – please use other side if necessary
	Not required

Name of reviewer: Anonymous .....

Date: 11/12/2014 .....

Appendix 5: Transcription Notation

Symbol	Name	Use	Example
[text]	Brackets	Indicates the start and end points of overlapping speech.	T: how t[all are you al] S: [tall are you al]
=	Equal Sign	Indicates no brake or gap A pair of = signs at the end of one line and beginning of another line indicates no brake between lines Can also be used when a single speakers talk is broken up in the transcript but is actually through produced	T: that will be five pounds = S: = what T: yeah well ok= S =[yeah T [I just thought I'd ask
(# of seconds)	Timed Pause	A number in parentheses indicates the time elapsed, in tenths of seconds, a pause in speech.	T: that's a lot of work (0.3) T: you know S: well
(.)	Micropause	A brief pause, usually less than 0.2 seconds.	T: umm (.) well S: ok (.) T: sure
underline	Underlined text	Indicates the speaker is emphasising or stressing the speech. A small underline indicates lighter stress than a long underline	T: I have cooperated fully With the police
:::	Colon(s)	Indicates prolongation of an utterance. The longer the colon row the longer the prolongation	T: so:::: um what to do
ALL CAPS	Capitalised text	Indicates shouted or increased volume speech. Compared to speakers usual talk	T: NO I didn't S: oh ok
°text°	Degree symbol	Indicates whisper or reduced volume speech.	S: °I don't think so°
. or ↓	Period or Down Arrow	Indicates falling pitch.	S: he was like ↓stop that
? or ↑	Question Mark or Up Arrow	Indicates rising pitch. Like asking a question	T: what do you ↑mean
>text<	Greater than / Less than symbols	Indicates that the enclosed speech was delivered more rapidly than usual for the speaker.	
<text>	Less than /	Indicates that the enclosed	

	Greater than symbols	speech was delivered more slowly than usual for the speaker.		
(h)		When a bracketed 'h' appears it means that there was laughter within the talk		
((italic text))	Double Parentheses	Annotation of non-verbal activity. Transcribers description	T:	((*cough*)) excuse me
(hhh)		Audible exhalation	T: S:	do you agree (hhh) I guess so
? or (.hhh)	High Dot	Audible inhalation	S:	(.hhh) oh no
(text)	Parentheses	Speech which is unclear or in doubt in the transcript.	T: S:	where did you stay I stayed at (south avenue)
()	Empty Parentheses	unable to get what was said	T: S:	where did you stay I stayed at ()
. , ? *?*	Punctuation markers	Punctuation markers are used to indicate 'the usual' intonation. The italic question mark indicates a weaker rise than a standard question mark	S:	oh I'd say he was about what. Five three and a half? Aren't you,
-	Hyphen	Indicates an abrupt halt or interruption in utterance.		

Appendix 6: STOPP Worksheet

STOPP Worksheet

Some materials have been removed due to 3rd party copyright. The unabridged version can be viewed in Lancester Library - Coventry University.

Appendix 7: The Cognitive Therapy Scale Revised (CTS-r)

Student code **Score** ...

COGNITIVE THERAPY SCALE - REVISED (CTS-R)

I.-M. Blackburn, I.A. James, D.L. Milne & F.K. Reichelt

Collaborators:
A.Garland, C. Baker, S.H. Standart & A. Claydon

Newcastle upon Tyne, UK - August 2000

Appendix 8: Glossary of Acronyms

BA - Behavioural Activation Strategies: BA strategies are used in CBT to enable service users to examine the relationship between their behaviours and affect, to maximise the service user's engagement in mood elevating activities. BA strategies include: monitoring activities (recording levels of activity and mood), scheduling activities (plan each day to increase activity levels) and graded task assignment (breaking tasks down into small manageable steps).

CA - Conversation Analysis: CA is a method for the analysis of naturally occurring interaction. It views language as a site for social action. CA focuses on the design of language at a technical level, focusing on the communicative competencies that inform interaction.

CB - Core Belief Strategies: CB strategies are used in CBT to identify, challenge and modify dysfunctional beliefs about the self, world and future. CB interventions include developing an alternative case formulation, cognitive restructuring (via use of the continuum technique), core belief logs and historical reviews.

CBT – Cognitive Behavioural Therapy: CBT is an evidenced based therapy used to treat a range of mental health problems. It is an "active, directive, time-limited, structured approach … based on an underlying theoretical rational that an individual's affect and behaviour are largely determined by the way in which they structure the world" (Beck *et al* 1979: 3). CBT is based on the cognitive model of emotional disturbance which centres on the relationship between thoughts, emotions, physical symptoms, behaviour and environment. It emphasises the central role of thoughts and thought processing (Kingdon and Dimech, 2008).

CBT MSc - Cognitive Behavioural Therapy Masters of Science: This is a qualification and the name of the training course in which to gain this qualification. The training aims to increase students' knowledge base of theory and research in CBT. The course also provides practical, intensive and detailed skills training to facilitate skills development to a defined standard of competence.

CBT PGDip - Cognitive Behavioural Therapy Postgraduate Diploma: This is a qualification and the name of the training course in which to gain this qualification. The

training aims to increase students' knowledge base of theory and research in CBT. The course also provides practical, intensive and detailed skills training to facilitate skills development to a defined standard of competence.

CDA - Critical Discourse Analysis: CDA is a version of discourse analysis that is concerned with how the abuse of social power, dominance and inequality are enacted, reproduced and resisted in text and talk in social and political settings (Lyons and Coyle, 2016: 368).

CR - Cognitive Restructuring Strategies: CR strategies are used in CBT and involve evaluating negative automatic thoughts. CR strategies include: identifying the NAT via self-monitoring techniques such as thought records, testing the NAT by examining evidence for and against it, evaluating the advantages and disadvantages of the NAT and behavioural experiments.

CTS-r – The Cognitive Therapy Scale Revised: This is a scale for measuring therapist competence in Cognitive Therapy and is based on the original Cognitive Therapy Scales (CTS, Young and Beck, 1980, 1988). It contains 12 items (see appendix 7).

DA – Discourse Analysis: DA is referred to in this thesis as a form of analysis that views language as a form of social action, addresses the social functions of talk and considers how these functions are achieved (Lyons and Coyle, 2016: 369).

DP – Discursive Psychology: DP is the theoretical perspective adopted in the current research project. DP is the application of discourse analytic principles to psychological topics (Edwards and Potter, 2001). DP focuses on the occasioned, action-oriented and constructed nature of discourse (Edwards and Potter, 1992).

DSM - The Diagnostic and Statistical Manual of Mental Disorders: The DSM is a standardised diagnostic tool providing standard criteria for the classification of mental health disorders. Used for epidemiology, health management and clinical purposes.

FDA - Foucauldian Discourse Analysis: FDA is a version of discourse analysis that is concerned with the availability of discursive resources within a specified cultural context and the implications for people within that context. These implications tend to

be examined in terms of identity and selfhood, ideology, power relations and social change (Lyons and Coyle, 2016: 370).

GAD-7 - The Generalised Anxiety Disorder Questionnaire: The GAD-7 is an easy-to-use self-administered patient questionnaire. It incorporates DSM-IV diagnostic criteria for anxiety and other leading anxiety symptoms into a brief 13 item self-report scale. The GAD-7 is used as a screening tool and severity measure for generalised anxiety disorder.

IAPT – Improving Access to Psychological Therapies: IAPT is a large-scale initiative for improving access to psychological therapies for depression and anxiety disorders within the NHS (Clark *et al* 2009). The IAPT service predominantly offers Cognitive Behavioural Therapy (CBT) for depression and anxiety, as recommended by the National Institute for Clinical Excellence (NICE) (Clark *et al* 2009).

ICD - The International Statistical Classification of Diseases and Related Health Problems: The ICD is a standardised diagnostic tool providing standard criteria for the classification of all health disorders. Used for epidemiology, health management and clinical purposes.

NAT - Negative Automatic Thoughts: NAT is a term used in CBT. NAT's are immediate, quick, first, thoughts or images that are generated in response to a situation. NAT's are referred to as negative because they are associated with unpleasant emotions and automatic because they are generated involuntarily without deliberate reasoning.

NHS – National Health Service: The NHS provides healthcare for all UK citizens based on their need for healthcare rather than their ability to pay for it. It is funded by taxes.

PhD – Philosophy Doctorate: A PhD is a postgraduate academic degree awarded by universities and higher education institutions to a candidate who has submitted a thesis or dissertation, based on extensive and original research in their chosen field.

PHQ-9 -The Patient Health Questionnaire: The PHQ-9 is an easy-to-use self-administered patient questionnaire. It incorporates DSM-IV depression diagnostic criteria and other leading depressive symptoms into a brief self-report tool. The PHQ-9 is used as a screening tool and severity measure for depression symptomology.